VOLUME 44
NUMBER 11
MONTREAL
NOVEMBER
1948

INDICATIONS FOR AMPUTATIONS
J. C. Luke, M.D.

RESPIRATORY INFECTIONS
W. R. Feasby, M.D.

BLOCK SYSTEM

SUPPER TIME

When you say "USEFUL" hands, LISP!

KEEPING *useful* hands *youthful* is a problem, and nowhere is this truer than in the nursing profession. Passive, useless hands require a minimum of care. Active hands need active measures.

Counteract the innumerable washings necessary in any hospital and keep your hands soft, white and attractive by using 'Wellcome' BRAND Toilet Lanoline *daily*. Massaged gently into the hands every night and, used more sparingly, in the morning after washing, this soft, soothing cream will supplement the natural oils of the skin and give "on duty" hands that "off duty" look.

Tubes of two sizes at all reliable pharmacies.

'WELLCOME' BRAND

Toilet Lanoline

BURROUGHS WELLCOME & CO.
(The Wellcome Foundation Ltd.)
MONTREAL

For a generous free sample simply mail this card to P.O. Box 159, Montreal.

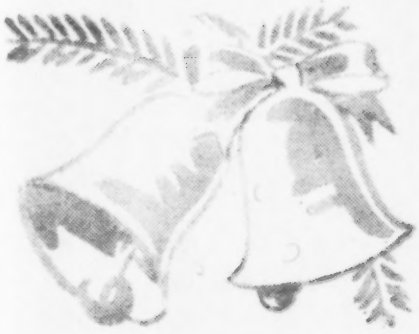
Please send me a free sample of Wellcome BRAND *Toilet Lanoline.*

Name.....

Address.....

.....

WHAT SHALL I GIVE **HER** FOR Christmas . . .



TURN THIS LEAFLET OVER

AND YOUR PROBLEM

WILL BE SOLVED!

THE CANADIAN NURSE,

MONTREAL 25, Que.

Subscription Rates: $3.00 per year. 2 years for $5.00.
$3.50 per year, U.S. & Foreign.

Special Student Nurse Rates:
1 year for $2.00.
3 years for $5.00.

Please send THE CANADIAN NURSE as a Christmas gift to:

PLEASE PRINT CLEARLY

1. Name Miss/Mrs.....(New or Ren.).....

   Street.....

   City & Zone No.....Prov.....

2. Name Miss/Mrs.....(New or Ren.).....

   Street.....

   City & Zone No.....Prov.....

And on the Gift Card state from:

Name Miss/Mrs.....

Street.....

City & Zone No.....Prov.....

I enclose.....as payment in full.

Please make all cheques, postal notes, money orders, etc. payable to THE CANADIAN NURSE.

New vitamin factors in canned foods

THE ROLE of the newer B complex vitamins in mammalian nutrition has been studied by a number of investigators in the last few years. Biotin, pyridoxine, and "folic acid" have been shown by animal experiment to be essential (1).

"Folic acid" has also been reported as effective in the treatment of sprue and certain other types of human anaemia (2, 3).

While the physiological properties and human requirements of these new vitamins are not fully understood or completely established, they will probably be elaborated in the near future.

In anticipation of that time attention is being directed to the occurrence of these factors in foods.

Tabulated below are the amounts of these nutrients found in representative canned foods (4).

It is planned in future work to develop more complete information regarding the biotin, pyridoxine and "folic acid" values of this important class of foods.

Pyridoxine, Biotin, and "Folic Acid" Contents of Canned Foods

(Recalculated in terms of four-ounce (113 grams) servings.)

		Pyridoxine	Biotin	"Folic Acid"	
				S. Lactis Factor	L. Casei Factor
Product	No. of Samples	Average Micrograms Per Serving	Average Micrograms Per Serving	Average Micrograms Per Serving	Average Micrograms Per Serving
Asparagus, Green	10	34	1.9	6.6	10.1
Beans, Green	11	36	1.5	3.3	8.7
Carrots	10	25	1.7	1.5	4.6
Corn, Yellow	10	77	2.5	1.9	6.3
Grapefruit Juice	11	16	0.3	0.6	1.4
Peaches	9	18	0.2	0.6	1.7
Peas	10	52	2.4	1.9	5.0
Salmon	10	147	11.1	2.9	7.8
Spinach	10	68	2.6	8.4	23.4
Tomatoes	10	80	2.0	3.0	6.1

(1) Nutrition Reviews *4*,163 (1946) (3) Am. J. Pub. Health *37*, 688 (1947)
(2) Nutrition Reviews *4*,11 (1946) (4) Journal of Nutrition *31*, 347 (1946)

CANCO

AMERICAN CAN COMPANY

KENTVILLE • MONTREAL • HAMILTON • TORONTO • WINNIPEG • VANCOUVER

THE CANADIAN NURSE, MONTREAL 25, Can.

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa.
Editor and Business Manager:
MARGARET E. KERR, M.A., R.N., Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

CONTENTS FOR NOVEMBER, 1948

INCENTIVES 885
INDICATIONS FOR AMPUTATION OF THE LOWER EXTREMITY ..... *J. C. Luke, M.D.* 887
NURSING CARE OF THE AMPUTEE ..... *J. Trenholme and F. Gass* 889
"R.D." THE SCOURGE OF THE TEMPERATE ZONE ..... *W. R. Feasby, M.D.* 893
THE BLOCK SYSTEM OF NURSE EDUCATION ..... *N. Street* 899
"STUDY DAYS" FOR NURSES IN TRAINING ..... *M. Marshall* 900
BOOT STRAPS ..... *A. Simson-Rathbone* 902
ROTATION OF STUDENTS ..... *Sr. Françoise de Chantal* 905
PEDIATRIC TRAINING, O.G.H. ..... *Sr. Raymond de Marie* 907
EPILEPSY ..... *E. M. Pullan* 910
ANTHRAX ..... *M. A. Ward* 913
IMPORTANCE OF ORIENTATION PROGRAMS FOR NEW EMPLOYEES ..... *B. M. Hunter* 917
SERVICE GÉNÉRALISÉ DE L'INFIRMIÈRE DANS UN SERVICE D'HYGIÈNE PUBLIQUE ..... *A. Groulx, M.D.* 920
IMMUNIZATION IN A RURAL DISTRICT ..... *C. C. MacDougall* 925
NOTES FROM NATIONAL OFFICE 927
NOTES DU SECRÉTARIAT DE L'A.I.C. 928
NURSING PROFILES 930
IMPRESSIONS OF THE "BLOCK SYSTEM" ..... *M. Loftus* 934
WE LIKE BLOCK TEACHING ..... *J. Conlin and J. Houghton* 935
ITINERARIES TO INCLUDE I.C.N. — 1949 937
BOOK REVIEWS 939
NEWS NOTES 946

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

Subscription Rates: $3.00 per year — $5.00 for 2 years; Foreign & U.S.A., $3.50; Student Nurses, $2.00 per year — $5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to *The Canadian Nurse*. (When remitting by cheque, add 15 cents for exchange.) *Change of Address:* Four weeks' advance notice, and the *old* address, as well as the *new*, are necessary for change of subscriber's address. Not responsible for *Journals* lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. *Editorial Content:* News items must reach the *Journal* office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. *Official Directory:* Published in March, June, Sept. & Dec. issues.

Address all communications to *Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.*

Nurses must guard against pain that can interfere with their work and take the pleasure out of their off-duty hours. Keep "217" Tablets readily available for fast protection when pain threatens or strikes. The handy tube fits conveniently in pocket or purse. The economy sizes of 40 and 100 tablets are ideal for home or office use.

Relieve

HEADACHES

NEURALGIA

RHEUMATIC PAIN

and COLDS

Frosst

Charles E. Frosst & Co.
MONTREAL CANADA

Between Ourselves

Within the past decade, the use of the antibiotics in the treatment of scores of disease conditions and with post-operative patients has bred a familiarity and confidence in their value that is frequently misplaced. Nowhere is this reliance on the sulfonamides or penicillin more commonly a false cure than in their unprescribed use in the **Respiratory Infections.** It is very common practice for the person with a cold or a sore throat to suck penicillin lozenges in the vain expectation that the infection will be relieved. Dr. Feasby verbally frowns on this self-dosage. Referring to the common cold he says: "Every person has his own pet remedy—none of them makes the slightest difference to the course of the disease. Some of them make the disease worse or produce a worse condition. The best example of this is seen when an individual prescribes sulfadiazine for himself and develops an anuria and dies. Penicillin has not been found useful in the common cold." Read his informative article on "R.D."—The Scourge of the Temperate Zone.

One hundred years ago, a fractured leg was considered grounds for **Amputation.** Today, very serious consideration is given to every amputation to make sure it is absolutely essential. The surgeon wants to remove as little as is absolutely essential in order to cripple the patient as little as possible. Dr. Luke stresses these points very clearly. How to deal with the "phantom leg" problem is clearly outlined in the article on the nursing care of amputees.

With the focus of attention being placed today on making the training of the student nurse more truly an educational experience, the **Block System** of time-table planning is receiving attention in a large number of our schools of nursing. We have concentrated a number of articles on that topic in this issue in order that every nurse may be well informed on the advantages and disadvantages of this type of program. It is discussed from the viewpoint of director, instructor, and student. In general, the consensus is exceedingly favorable. As a contrast, we suggest you read also Miss Marshall's description of the "study days" program that has been evolved in Britain.

Private duty nurses have a very excellent opportunity to study the cause and effect of disease conditions and their treatment to a far greater degree than does the graduate engaged in general staff work. In the great majority of cases, their patients are the critically ill. They care for many of the less commonly seen conditions. One of these is described in careful detail on the special Private Duty Nursing Page. Miss Ward's picture of the distress of an **Anthrax** patient makes very informative reading. We would be delighted to have a dozen similar articles as quickly as our private duty nurses can assemble and transcribe the data. Share your valuable information and experience with your colleagues.

The emphasis in next month's issue is to be on the subject of **Tuberculosis.** We have a wide range of aspects of this disease which we shall present for your consideration.

Blood Transfusion Service

The national chairman of the Red Cross Blood Transfusion Service reported recently that within a year free blood transfusions will be available for the majority of Canadians, as five new provinces have agreed to this service which is already operating in British Columbia and Alberta.

In these two provinces, 17,221 patients received free blood and plasma through the Blood Transfusion Service during 1947. More than 23,000 bottles of blood and plasma contributed by 33,500 voluntary donors were prepared and used. The Transfusion Service provides the blood and blood products to Canadian hospitals, on the condition that they are given free of charge to all who need them.

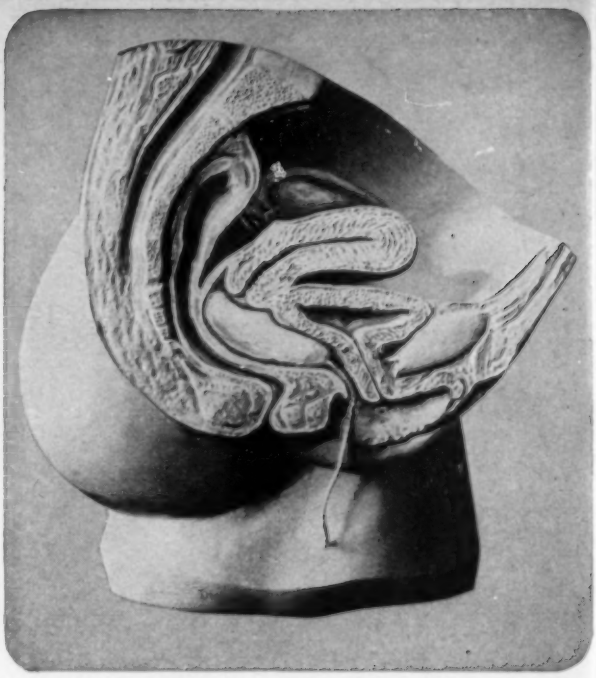
— *The Red Cross World*

POTENCY

The comprehensive controls under which Aspirin is made insure uniform potency. In all, over seventy different tests and inspections are employed in making this best-known of all analgesics. The Aspirin reputation and acceptance as *the* analgesic for home use is being jealously guarded. In one of the world's finest drug plants where Aspirin is made, *excellence* is the standard.

TAMPAX FACTS NO 2

... It is "free from harm or irritation to the vaginal and cervical mucosa ..."[1]



By practically every known medical criterion, TAMPAX has been proved physiologically safe . . . clinically adequate . . . and esthetically acceptable. In one study[1] involving 2000 cases and extending over a five-year period, TAMPAX was used with "most favorable" results. Of this group, 36 subjects inserted TAMPAX *twice daily for an entire year*, and no irritation or vaginal changes were observed. In another investigation,[2] where 21 women used TAMPAX for 3 to 5 months, it was noted that "the vaginal canal is less likely to become irritated by a tampon (TAMPAX) than the vulva (hair follicles, sweat and sebaceous glands) by an external pad."

These and many other careful projects[3,4,5,6,7] in recent years have firmly established the full safety of TAMPAX: the fact that it does not irritate—obstruct the flow—nor cause vaginitis or erosion. And TAMPAX users themselves (2 billion TAMPAX tampons have been purchased in the last 14 years!) by their steadily increasing number, provide further dramatic evidence of the sound clinical value of this *internal* menstrual guard.

References: 1. West. J. Obst. & Gynec., 51:150, 1943
2. Clin. Med. & Surg., 46:327, 1939
3. J. A. M. A., 128:490, 1945
4. Am. J. Obst. & Gynec., 48:510, 1944
5. Am. J. Obst. & Gynec., 46:259, 1943
6. Med. Rec., 155:316, 1942
7. Med. Rec. & Ann., 35:851, 1941

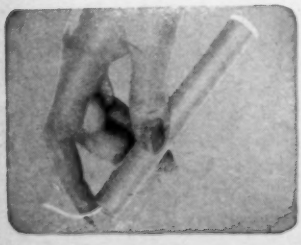
TAMPAX

The Internal Menstrual Guard of Choice

TAMPAX is available in three absorbencies, Regular, Junior and Super.

With this range of absorbencies the menstrual flow of almost all women may be suitably accommodated throughout the entire period. Just fill out and mail the coupon for professional samples.

Accepted For Advertising By The Journal Of The American Medical Association.



CANADIAN TAMPAX CORPORATION LIMITED,
Brampton, Ontario.

Please send professional supply of TAMPAX in the three absorbencies and related literature.

Name.....
PLEASE PRINT

Address.....

City..... *Prov*..... P8-16

New young crops for new young Canadians

Here, in the sunniest southernmost tip of Canada, the Heinz kitchens at Leamington capture the goodness of fresh vegetables at their prime. The new 1948 pack of Heinz Baby and Junior Foods is now well distributed. Dealers everywhere have complete stocks of 25 varieties of Heinz Baby Foods and 16 varieties of Heinz Junior Foods, all processed with scientific care to retain minerals and vitamins in high degree.

You can now recommend any or all of these Heinz foods for the young Canadians in your charge with full confidence that they are abundantly available.

Heinz Baby Foods

Buy them from Bland

Bland's Capes are superb. They're so cosy. They're good looking and they'll last almost a lifetime.

•

In fine serges, cheviots and velours.

•

You may have a catalogue.

Write to:

Bland & Company Limited
1253 McGill College Ave.
Montreal, Canada

PROVEN BETTER for Infant Skin Care . . .

NEW! JOHNSON'S BABY LOTION

NEW, yes—but previously tested over a period of two years on several hundred infants in a recognized hospital nursery—Johnson's Baby Lotion provides a better, surer means of controlling babies' skin irritations!

Results of routine care with this antiseptic, smooth, white Lotion reveal its special properties . . . show that Johnson's Baby Lotion is a valuable, ideal aid in the amelioration and prevention of such conditions as miliaria.

Micron-size oil globules (1000x) are seen in discontinuous film of Johnson's Baby Lotion.

Johnson's Baby Lotion is a finely homogenized emulsion of pure selected mineral oil and water, with a mild antiseptic (hydroxy quinoline) added. As the water phase evaporates, a discontinuous film (see photomicrograph) is left on the infant's skin.

This permits normal heat radiation and allows perspiration to escape readily, thus lessening the danger of irritation.

JOHNSON'S BABY LOTION

Johnson-Johnson
LIMITED MONTREAL

FREE! Mail coupon for a trial bottle!

Johnson & Johnson Limited, C.N.-118
Baby Products Division,
2155 Pie IX Boulevard, Montreal.

Please send me, free of charge, a trial bottle of Johnson's Baby Lotion.

Name .....

Street .....

City .....Prov.....

So-o-o SMART
So-o-o COMFORTABLE!

"White Uniform" shoes by Savage are always "on call" among nurses who demand smart styling as well as comfort. These shoes represent a combination of skillful designing and expert craftsmanship in making shoes that will provide long wear and lasting beauty.

"White Uniform" shoes by Savage have noiseless white soles and heels, and are built on lasts which properly represent every contour of the healthy foot. They are comfortable because they encourage correct balance and weight distribution. Soft pliable uppers are perforated to permit a comfortable airiness.

THE Savage Shoe Company Limited

PRESTON, ONTARIO

Give uniforms *that crisp look without that stiff feel*

Add DRAX to STARCH!

You'll be extra proud, extra pleased with every uniform you turn out of your laundry, when you add DRAX to starch. DRAX and starch make an unbeatable rinsing combination – all the crispness, freshness you want, yet none of the scratchy, boardlike feel.

Uniforms look smoother, better – are more comfortable. DRAX adds pliability to starch – keeps garments from cracking and creasing. DRAX makes uniforms soil-resistant too – they stay clean longer – are easier to clean!

DRAX helps cut uniform replacement costs, because uniforms need less hard, less frequent launderings, they wear longer. DRAX-treated garments are easier to iron (20% easier by actual test). You'll be amazed at how economical and easy DRAX is to use. For only a few pennies you can DRAX dozens of garments. No extra equipment or special skills needed – simply add DRAX to your starch solution. Or mix it in your final rinsing water. Find out about DRAX today. Write S. C. Johnson & Son, Ltd., Brantford, Canada.

DRAX is made by the makers of **JOHNSON'S WAX**

(a name everyone knows)

"Johnson's" and "DRAX" are registered trademarks.

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

THESE HELPING HANDS...

The hands that care for the patient so skillfully deserve some extra care themselves. Miss E. M. P., registered nurse, writes: "Hospital work is hard on hands, and I find especially that the different disinfecting solutions make my hands very rough and red. When I finally started using Noxzema, I was delighted with its quick effectiveness and the remarkable improvement in the way my hands look. I find Noxzema helps heal minor burns and many other skin discomforts, too."

Let Noxzema nurse your hands

THERE'S REAL HELP for "helping hands" in Noxzema Medicated Skin Cream. For many years it has been a standby in the nursing profession.

Unlike ordinary hand creams, Noxzema has a medicated formula that actually helps heal the tiny cuts and cracks your hands get from strong hospital solutions. It soothes and softens red, rough skin . . . smooths away that work-worn look . . . and helps even severely chapped hands heal faster. Keep a jar handy and use Noxzema often; it's greaseless and won't stain clothing or bed linen.

P. S. There's nothing like Noxzema for sunburn. It gives cool, soothing relief in just a few minutes—and you can actually feel it heal. Its medicated formula takes out the fire of sunburn . . . keeps you comfortable even in a stiff, starched uniform.

Get a jar of Noxzema today at any drug or cosmetic counter.

IMPROVED FORMULA

NOW ADDED!

THREE ESSENTIAL VITAMIN B-FACTORS

- SIGNIFICANT AMOUNTS
- BALANCED RATIO

IRON as dried ferrous sulphate—protected—stable—readily assimilated

NO CHANGE HAS BEEN MADE IN THE FORMULA OF HEMATINIC PLASTULES PLAIN

Wyeth
Registered Trade Mark

Readily Digestible
MILK MODIFIERS
for INFANT FEEDING

Crown Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.

"CROWN BRAND" *and* "LILY WHITE" CORN SYRUPS

Manufactured by THE CANADA STARCH COMPANY Limited
MONTREAL AND TORONTO

THOUSANDS OF BABIES HAVE RESPONDED TO

"FARMER'S WIFE" MILK

Half-skimmed • Irradiated • Concentrated

Mothers rely on their doctors to recommend the best milk for their babies. "Farmer's Wife Milk" is already well-known among doctors, nurses and hospitals — as an ideal milk for both normal and delicate infants. That's why so many doctors recommend "Farmer's Wife". Its lower fat content makes it easier to digest. It's an excellent source of Vitamin D — 400 International Units per reconverted quart, giving better protection against rickets. It promotes good bone and tooth development.

Please write for literature and pocket formula card.

COW & GATE (CANADA) LIMITED
GANANOQUE, ONTARIO

TABLETS

SOLUBLE TABLETS

TABLETS FOR PEDIATRIC USE

THROAT LOZENGES

OINTMENT

Practical PENICILLIN *Developments*

The great amount of clinical work that followed the introduction of penicillin has resulted in the employment of this antibiotic for localized as well as systemic infections. To conform with these increased indications, new forms and strengths of Ayerst penicillin have been developed. The variety of these products, offered under the trade name "Cillenta", facilitates treatment for both physician and patient.

Ayerst

"CILLENTA"

Ayerst brand of penicillin

AYERST, McKENNA & HARRISON LIMITED • *Biological and Pharmaceutical Chemists* • MONTREAL, CANADA

524

For little people with big ideas . . .

A sick child, even at best, presents a problem—especially when it comes to downing unpleasant, hard-to-take medication. That is why so many doctors and parents have welcomed Sulfadiazine *Dulcet* Tablets. These palate-tempting pink cubes were designed from the child's point of view as well as the physician's. In appearance, odor and taste, they are candies. As medication, they are accurately standardized to produce the same therapeutic results as sulfadiazine in ordinary form. Children like them, and so do adults who find it difficult to swallow tablets or capsules. Sulfadiazine *Dulcet* Tablets may be chewed, dissolved in the mouth as troches, or crushed and taken in a spoonful of water. Supplied in bottles of 100. 0.3 Gm. (5 grs.) tablets. ABBOTT LABORATORIES LIMITED, Montreal.

SULFADIAZINE *Dulcet*® TABLETS

(Medicated Sugar Tablets, Abbott)

The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-FOUR *NUMBER ELEVEN*

MONTREAL, NOVEMBER, 1948

Incentives

WITHIN recent months, a Canadian periodical referred, in its columns, to the approval of the principle of collective bargaining for nurses through their own associations which has been recorded by the membership of the C.N.A. Interpreting this action as a step "in the foreseeable future to unionization," the comment concludes with these statements:

> The hard fact of the matter is that there are not enough nurses to maintain a minimum health standard in Canada today. Part of the reason for this lies in the fact that the profession at the moment is not sufficiently attractive, and we believe never will be until the nurses themselves as an organized experienced body are prepared to lay down their own conditions of work.

It is axiomatic to state that a professional organization, such as the C.N.A., should be concerned regarding the economic and social welfare of its members. Though no national committee has, so far, been instructed to develop any form or model of plans for proposed personnel policies, endorsation has been given to the patterns which have been evolved by many of the provincial associations who are the federated members of our national body. The Alberta and British Columbia associations particularly have given leadership in the formulation of explicit policies. The latter has published a leaflet entitled "1948 Revision of Recommendations on Personnel Policies." Copies are available from their provincial office. Other provincial associations have committees at work on this matter. The problem of setting up "conditions of work" is thus being given essential consideration.

Is that all that is necessary to remove the current feelings of unrest? Is it just a question of settling upon a suitable figure as compensation for a work-week of such-and-such a length or so much per hour for private duty care? Experience has proven otherwise. The emphasis placed on money alone, or even the inclusion of some of the physical comforts in the nurses' residences, will not supply the essential incentives or motives which will lead to greater co-operative effort. What else is needed?

Walter L. Sachs has made some trenchant comments on the incentives commonly employed by industry to

increase the individual worker's performance. Writing in the March-April, 1948, issue of *Industrial Welfare and Personnel Management*, published in Britain, Mr. Sachs says:

> Methods used in industry to induce the worker to work harder are rather primitive. They rely largely upon the time-honoured principle of the carrot and the stick . . . At a time when so much depends upon the exertions of the individual workers the two incentives mainly in use have lost much of their effectiveness. Fear as an incentive does not count at a time when pre-war unemployment has given way to a post-war labour shortage . . .
>
> Financial incentives, too, have lost much of their power. They are necessary and should be used much more than they are, but they will not ensure maximum output.

There is no denying that these two incentives have played a powerful role in nursing. One has only to recall the situation that prevailed during the thirties to realize their significance. However, the belief in financial gain as the only one dominant motive for work is described by Mr. Sachs as "a pernicious fallacy which has in the past seriously retarded the evolution of industry as a truly human institution." He states that "the lot of the group has been bettered, but little has been done to change the position of the worker in the group and his basic relationship to his work."

> The most disastrous effect of the disregard of non-financial motivations has in my opinion been the degradation of work in the worker's own mind. It is seen as a mere lever to extract wages from the boss, a painful necessity devoid of any spiritual or personal value.

In a search for new incentives which would result in increased satisfaction in work, Mr. Sachs enumerated four spheres in which success is important: social relations, personal achievement, advancement and promotion and, lastly, financial gain. The ingredients which go to form the first three are collectively styled "psychological incentives." These include such processes as promotion, public recognition, improved status, and educational facilities. He suggests that if instead of asking the worker to produce more, he be urged to work better, the appeal constitutes an acknowledgement of the worker's intelligence and provides "the fascination of an interesting problem" in the study of ways and means whereby this may be accomplished.

A nurse's work can give her many forms of recompense, such as: satisfying the longing for encouragement and appreciation; the need of personal achievements as the basis for self-respect and inner security; the opportunity for self-expression; reaching her desired goal of progress and advancement. These are the intangible incentives which all too often are lost sight of these days. As a result of this lack, nurses, in common with workers everywhere, are "suffering from a deep though mostly unconscious feeling of frustration." This "inner uneasiness" causes nurses to withhold their full co-operation and prevents them from assuming their full share of responsibility for conditions as they exist. Let us give full recognition to *all* of the incentives in our planning.

Orthopedic Impairment

Poliomyelitis is the leading cause of orthopedic impairment among young people, accounting for one-fifth of the handicapped under twenty-one. Second in rank is cerebral palsy, a condition which has received little attention until recent years. Most communities have failed to recognize the magnitude of the problem, or to provide even a minimum of services for children with this disease. This is unfortunate, because, with proper methods of treatment, education, and physical rehabilitation, about one-half of the victims can be helped to attain economic self-support and general social adjustment. It is encouraging to note, however, that studies are now underway to determine the best ways of preventing and treating the condition.

— *M.L.I. Statistical Bulletin*

Indications for Amputation of the Lower Extremity

JOSEPHUS C. LUKE, M.D., F.R.C.S. (Eng.) and (C)

INTRODUCTION

IN INTRODUCING the topic of the care of the amputee, it is fitting that a few words be said on the medical reasons for amputation, the selection of the level of amputation, and the surgical technique involved.

The decision to sacrifice a patient's limb is a grave one and involves the consideration of a number of factors. It is a decision where at times there is no alternative, such as in the case of a gangrenous foot or a badly pulped leg, but, in other cases, amputation is only one means to cure the patient's difficulties and, as such, needs very mature consideration. A wise plan is that adopted by the Canadian Army where agreement by three surgical specialists was necessary before a limb was sacrificed. From the surgeon's standpoint, the removal of a part of the leg is more than a mere operation. He must first of all attempt to assess the psychic stamina of the patient to determine how he will react to the loss of a leg and he must beforehand attempt to allay the patient's fear that such an operation will mean a life of invalidism. An excellent method is to demonstrate other amputees who are carrying on useful lives. Most people know of many such examples especially since the late war. The surgeon is responsible for the determination of the proper level of amputation, for the performance of the correct surgical procedure, and for ensuring that proper healing results following the operation. In addition, it is the surgeon's duty to supervise the nursing care, the physiotherapy given, and to arrange for a suitable prosthesis when the stump is properly healed.

Dr. Luke is a surgeon on the staff of the Royal Victoria Hospital, Montreal.

INDICATION FOR LEG AMPUTATION

In the past, amputations were more frequently performed than at present. Before the era of antisepsis, a compound fracture of the leg invariably became infected and, as it was a menace to the patient's life, was consequently amputated. At present, with our improved surgical technique and especially since the advent of the antibiotics, such a sequel practically never follows. More limbs are being saved today than ever before.

In a survey of the major amputations done at the Royal Victoria Hospital, Montreal, between the years 1936-46, it was found that 141 were performed. Thirty-nine were necessary as a result of accidents, while 102 were the sequel to disease. Of this latter group, all but three needed amputation because of gangrene resulting from blockage of the arterial inflow to the leg. Consequently, it can be seen that the major reason for the amputation of the leg in a civilian hospital is arterial disease. The most important of these diseases is arteriosclerosis which is an invariable accompaniment of old age and also prevalent in diabetics. Buerger's disease, arterial embolism, and arterial thrombosis due to various causes are also factors. Occasionally a limb must be sacrificed because of malignant disease such as sarcoma occurring in some portion of the leg. In warfare, the etiology is entirely traumatic and the large number of legs lost is due to the mangling effect of missiles and mine explosions which either produce a traumatic amputation or so damage the limb or the blood supply to the limb that it must be removed.

DETERMINATION OF LEVEL OF AMPUTATION

As a general statement it can be

said that the more limb a patient has the better will be the future progress of his rehabilitation. But, as has been said, the majority of civilian amputations are done for arterial blockage and consequently healing of the amputation wound is poorer the farther toward the foot the operation is done. It is, therefore, a question of judgment on the surgeon's part to give the patient the maximum length of limb and yet ensure healing of the amputation wound. He is aided by the determination of the level of the arterial blockage, the oscillometric readings, the fluorescin and histamine flare tests.

In cases of arterial disease, one of four types of amputation is indicated: (a) The transmetatarsal amputation of the foot in lesser degrees of arterial blockage; (b) the below-knee amputation leaving 5-7 inches of tibia; (c) end-bearing stumps close to the knee such as the Stokes-Gritti or Callander types; (d) lower third of thigh amputations in the major degrees of arterial blockage.

An error in judgment on the surgeon's part, or technical faults, are serious in these cases because, in general, the patient is a poor risk. He is in the older age group and the tissues heal poorly because of the deficient vascular supply. A non-healing (and consequently infected) amputation stump invariably means a prolonged convalescence, increased mortality, and a second higher amputation.

Operation Details

In the performance of an amputation for arterial disease it must be borne in mind that this disease is not solely concerned with the leg. Such a condition involves all the arteries of the body to some degree, the most important of which are the coronary arteries of the heart, and the arteries supplying the brain. As a result, therefore, heart disease is common in such cases and the mental changes of senility are frequently present. The operation must be done as gently as possible and supportive treatment during the operation is absolutely imperative. Such treatment includes the giving of blood transfusions and the prevention of sudden drops in blood pressure which are poorly tolerated by older patients. It must be remembered that not only is blood lost during the actual operation but also that considerable blood is removed in the amputated limb.

Spinal anesthesia is best tolerated by the majority of patients but occasionally, when the patient's condition is so bad that any anesthetic is out of the question, actual freezing of the leg can be done. This so-called refrigeration anesthetic has the advantage of eliminating the need for actual anesthesia. The operation is painless, the patient can eat normally, and shock is absent. Its great disadvantage is in causing retarded healing.

Drainage of the wound is obligatory in most amputations to allow exit of the oozing and exudation which occurs. Such a drain should be removed in forty-eight hours. Adequate sedation is needed but this should be carefully watched as these older patients have a greater tendency to pulmonary atalectasis and bronchopneumonia if their respiratory rate is unduly depressed. Penicillin should be a routine to guard against the danger of infection in the stump. A relatively common post-operative complication in these cases is mental confusion and disorientation. Such a happening can occur to any older person following an operation but is especially frequent in the amputation cases. The explanation is probably brain damage (usually temporary), the result of a fall in blood pressure during operation when associated with arteriosclerosis of the brain arteries. The psychic trauma incident to the loss of a limb undoubtedly also plays a part. Fortunately, the majority of the cases clear spontaneously during convalescence providing that other complications are prevented.

Approximately one-half of the patients hospitalized by the Veterans Administration are veterans of wars other than World War II.

Nursing Care of the Amputee

JEAN TRENHOLME *and* FLORENCE GASS

THE NURSING care of the amputee can be divided into the three phases of the patient's illness: period before operation, the immediate post-operative period, and the period of adjustment following, often spoken of as the rehabilitation period. The physical care is quite distinct as it applies to the three phases, but the mental nursing of such patients must pervade the nurse's whole association with him.

The total treatment of the amputee requires the combined efforts of physician, nurse, physiotherapist; in many cases the social service worker, and if the patient is in the age group where some prosthesis is practical, a representative of a company supplying artificial limbs should also be included in the group. Of all these, the nurse is the only one who has daily contact with each of the others in relation to her patient. This makes the part played by the nurse a most important one in the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.

The nurse being the most familiar figure to the patient will be the one to whom he brings all his difficulties, large and small. The small ones he expects the nurse to consider and give advice or encouragement as necessary. The larger ones, which may have to be handled ultimately by the doctor, may first be discussed with the nurse in order to get her viewpoint as to the advisability of presenting them to the doctor. The patient who is anxious to get completely well as quickly as possible is often not too anxious to have the doctor recognize the weak links in his make-up and is more ready to get his help through the nurse with whom he is more familiar.

The nurse, how ever accustomed she may be to seeing and caring for patients with amputations, must never lose sight of the fact that to each patient it is a new and terrifying experience that has to be faced. Throughout the period before operation, which is such a trial physically and mentally to the patient, an interested, understanding, sympathetic, but not pitying nurse can do much.

Miss Gass is an instructor and Miss Trenholme is a head nurse on the staff of the Royal Victoria Hospital, Montreal.

PRE-OPERATIVE CARE

In considering the actual physical preparation pre-operatively, there are a few things which apply to amputation cases directly, and then there are many things which we connect with the preparation for any major surgical operation. In considering the characteristic things we find that:

First, we must be very careful to prevent any contractures — that is, to avoid any position which allows a muscle to be shortened for long periods, for this favors the development of a contracture. It may be that a patient, suffering with a condition causing severe pain, will be found to lie or sit in a position — e.g., with the knee flexed or with the hip rotated outwards — in such a way that a contracture may develop. The patient should be encouraged to assume a good posture or position of good alignment by making him aware of this point and relieving the pain in other ways.

The second important point is the care of the unaffected limb. Most of our patients are diabetics with vascular conditions, possibly involving gangrene, necessitating the amputation of a leg. This treatment of the unaffected leg is very essential and important, most particularly in a diabetic, where we are continually teaching our patients to be careful of the skin, feet, nails, etc. In this instance we have to consider friction and the prevention of blisters — the nutrition of the skin is most important. Skin

which is dry and rough is easily cracked. As a preventive measure, lanolin or benzoated lard may be applied. It is also considered advisable to have either a snug fitting, but not restricting, white wool sock put on the foot, or have a pad applied to the heel, which is bandaged on securely. We consider the latter more satisfactory. One point must not be forgotten in the care of the diabetic. In bandaging the foot, separate, and bandage separately each toe to prevent any moisture collecting between the toes and causing the skin to break down.

In our care of the unaffected limb, we must also work to prevent foot-drop. We use wooden foot-boards which must be wrapped carefully to prevent any splinters being picked up or any other injury to the foot. The bed-clothes are raised from the patient's legs to prevent any discomfort by using a cage or cradle which, too, must be bound to prevent any injury to the skin of the affected or unaffected limb. Recently we have been using individual loops, usually two of them, to raise the bed-clothes and at the same time allow some freedom of movement. This is particularly helpful in handling meal trays, or to enable the patient to use an over-bed table and carry on other activities. A cage, one which was large enough to remove all the bed-clothes, was found to be rather limiting to any other activities. A small single-leg cage is never used.

Other points considered in the pre-operative care of the patient are ones which we think of in any major operation: absolute cleanliness, inside and out, preparation of the skin in the desired area by shaving. Our actual skin preparation is done in the operating-room. Care of patient's valuables, notification of relatives or friends, arrangements to see his priest or minister are all small things which mean much to the patient at this particular time. Pre-anesthetic sedation and other medications ordered for the pre-operative preparation must be attended to as ordered, as well as any special orders as in the case of ice anesthesia, where the nurse applies the Esmarch or rubber bandage, which is used to compress the blood vessels.

Throughout this period the nurse's encouragement and understanding is of vital importance. If the nurses could only put themselves mentally in the patient's situation for a few moments of those nerve-wracking minutes before the anesthetic is given!

Post-operative Care

The second phase is that of the immediate post-operative care. Here again we think of those things which are directly applicable to this type of operation.

Patient's position: This, of course, at first is determined by the type of anesthetic used. The body should be in good alignment, the stump included. There should be no pillow under the stump, preventing contractures. The weight of the bed-clothes is kept off with the loops or cage and the remaining leg will not have foot-drop, because the foot-board or support is also present. The protection and hygiene of the other foot is very important for any amputee, but doubly so for the diabetic, whose disease is not a direct cause of gangrene with amputation, but if the disease is uncontrolled his tissues provide excellent soil for rapid spread of the gangrene.

Further care is based on observation and recognition of complications of this man's operation, which could include:

Hemorrhage: Remember the bleeding is apt to be under the stump, so examine bottom sheet as well as the dressings and any discharge must be differentiated from the serous drainage.

Shock: Nurse must be observant for symptoms of pallor, increased pulse rate, decreased blood pressure, cold clammy skin, etc.

Infection may develop despite our aseptic precautions. Many of these patients are old and debilitated, arteriosclerotic and diabetic. Such patients are frequently incontinent, both of urine and feces, and not infrequently the dressing and wound of the stump may become soiled. (Diabetics seem to be predisposed to gas gangrene and the causative organism may

be present in the stool.) It is suggested that rubber tissue or heavy waxed paper might be wrapped about the dressing and secured to the leg with wide bands of adhesive reaching above the dressing.

Pulmonary embolus: The patient should be watched for chest pain, hemoptysis, cyanosis or collapse, particularly when getting the patient out of bed.

Often the patient is bothered with pain from the phantom or ghost leg, as it is sometimes called, due to the severance of the nerves which supplied the amputated extremity. This may be a sensation of uncomfortable position, or actual feeling of pain. There seems to be a direct relation between the amount of pain felt from the phantom limb with the amount suffered prior to the operation. In other words, one who has suffered severely for a long time previous to the amputation will probably have severe pain lasting over a period of weeks or months following the operation, whereas a person who lost his leg through accident would probably suffer very little from this cause. The patient should be given insight into the situation, he should be treated with sedation and suggestion as well, and he needs assurance that these feelings of discomfort or pain will disappear eventually.

Adequate back and skin care are most essential and the patient, after his first day, should have frequent position changes.

Occasionally, for amputations above the knee, skin traction is used. This has to be handled carefully. It has been found that it is advantageous to have a pulley system erected on either side of the foot of the bed so that the patient can be moved from side to side without limitation in movements. The traction is left on until the wound heals and the weights must not be taken off when nursing care is being given.

Rehabilitation

The third classification of care is rehabilitation. This phase actually starts at the very beginning of the patient's care, for the nurse is aiming to build up a positive mental attitude towards this adjustment which he will have to make in his social and vocational life.

The actual surgical dressings are done here by the surgeon or his interne until the wound heals. Then the nurse starts with her turn of bandaging in order to mould the stump in the desired form to fit the prosthesis. The directions as to how this bandaging is to be done are given either by the surgeon or the man from the company which is going to provide the prosthesis. Elastic crepe bandage or Ace bandages are used. These are reapplied at least once each day and very soon the nurse interests the patient in the application and has him doing it himself under her supervision. These bandages can be washed in warm soapy water, squeezed rather than wrung out, dried in a towel, and refolded loosely.

The position of the stump in relation to the rest of the body is of utmost importance. Good alignment must be maintained. Prevention of contractures in muscles proximal to the stump is of primary importance. But, at the same time, we must not neglect the rest of the body — the unaffected leg, which is going to bear the brunt of the weight, or the upper extremities, the shoulder girdle, which is going to be so concerned with crutch walking, previous to the prosthesis and getting in and out of the wheel chair.

Exercises are started early postoperatively. These should be designed to go through the various progressions gradually using more and more muscle groups with an increasing range of motion, correct posture being stressed at all times. These exercises should be carefully outlined to the nurse by the surgeon or physiotherapist. Physical therapy is of primary importance in this period of rehabilitation.

Since the services of a physiotherapist are not available in all communities, a brief outline of exercises planned by an individual who has had formal training in this line is of value to the nurse who assumes the responsibility of teaching the patient.

A very simple outline of exercises to be done several times daily is as follows:

1. Full flexion and extension of arms.
2. Weight-lifting above head (with dumb-bells — a book or something similar).
3. Use of short crutches in bed, before patient is up, helps prepare the patient psychologically and physically for crutch walking.
4. Full extension of hip, by placing a pillow under patient extending from shoulders to just above hips.
5. Prone lying position (after traction has been removed) to prevent hip flexion deformity.
6. Full flexion and extension of knee joints.
7. Full flexion and extension of ankle (of unaffected limb).
8. Strengthening of thigh muscles by alternately tensing and relaxing muscles with downward pressure on knee.
9. Later — crutch walking.

(a) Proper position of hand on crosspiece, bracing the upper end of crutch against chest wall, prevention of pressure on radial nerve, how to lift weight of body by extending elbows and depressing shoulder girdle.

(b) "Swing to" and "swing through" gaits.

In getting the amputee up into the wheel chair, a little more explanation about this phantom or ghost leg is due the patient. It is so real to him that it is difficult for him to get away from the idea of it not being there. There is always the danger of him trying to step out on it. If the patient is aware of this and reminded on getting up, there should be no difficulty — no danger of loss of balance and falling, with the undoing of all good work to date.

In our hospital, crutches are ordered by the nurse, but the responsibility of measurement for them falls upon the interne. It is deemed wise, however, for the nurse to know about the measuring. The directions given are to measure at the axilla, two inches from the arm-pits, to the floor at a point either five inches directly in front of the foot or eight inches to the side.

One important aspect of this program which does not concern the patient directly, but which is a vital part of the nurse's responsibility, is the instruction to the patient's family and friends. Over-anxiety and sympathy, although given with the best of intention, do little to help the patient back to normal living. The proper attitude, if developed in these people, can play a major role in the psychological readjustment of the patient.

We must not forget that the patient can return to a normal active life, and it is our duty to help him become a useful member of society.

Accident Death Toll

Accidents are the greatest single menace to the lives of children at the preschool ages. Each year approximately one-fourth of the deaths from all causes combined, occurring among children from 1 to 4, are due to accidents. Accidental death comes to children under a wide variety of circumstances, ranging from a fall on the floor at home to the crash of a seaplane into a lake.

Fatal mishaps involving motor vehicles were responsible for 34 per cent of the total accident death toll at these ages, while burns, conflagrations, or explosions accounted for an additional 27 per cent of the total; the two categories together thus were responsible for nearly two-thirds of the fatalities. Next in rank were drownings, with 13 per cent of the deaths, falls with 6 per cent, and poisonings with 5 per cent. It is a striking fact that in the total of youngsters run over or hit by an automobile in the last year, there were nearly twice as many boys as girls.

Youngsters from the time they begin to move about on their own until they are off to school will heedlessly venture wherever they can. Far too often, their curiosity leads them to destruction. At the preschool ages, more than in later years, safety of life and limb depends upon the constant vigilance of others. To keep an ever-watchful eye on young children is not an easy task, but the rewards are more than commensurate with the effort.

— *M.L.I. Statistical Bulletin*

"R.D."
The Scourge of the Temperate Zone

W. R. Feasby, B.A., M.D.

Like malaria for the tropics, in the temperate zones respiratory disease is just something that comes with the weather and people do not think very much about it. This group of diseases is important to every resident of the temperate zones. It creates vast problems for the medical profession, for industry, the state, and certainly for the individual.

Incidence

The numerical importance of R.D. is generally recognized. Almost every individual in Canada suffers a cold on the average at least once annually. The person who does not have colds is a rarity. This means that, as a rule, each individual loses, or is non-effective at his work for two days a year. In man-power days lost, this represents about twenty million days annually. The percentage of time lost yearly can be computed. It may be as high as 5 per cent of all available time for work. In the services, the importance of this wastage was only brought home to those in authority, when it was pointed out that for every two hundred thousand men on duty in Canada, one million training days per annum were lost through acute respiratory diseases. Those operating a registry or a school of nursing will be very familiar with the fact that one-fifth of the possible time available from the individuals for the performance of duties is lost through acute respiratory disease.

Attempts to reckon the loss in national income result in astronomical figures. The loss in money cannot be properly estimated. What is not realized fully is the loss of life and the crippling which result from acute respiratory disease. Very few of those suffering from them nowadays die at the time. However, the end result in loss of life is serious. Think of the chronic asthmatics, the persons with bronchiectasis, and those with rheumatic fever and nephritis who eventually die as a result of an initial acute respiratory infection. What can be done about all this?

A better understanding of the origin and cause of respiratory diseases is very important. There are many things which can be done to prevent them completely and to alleviate their dangers when they have developed.

Modes of Transmission

There are two principal modes by which respiratory diseases are spread. These are *contact* and *mediate* infection.

Contact infection: Infection by *direct contact* is self-explanatory. There are some persons who need to have it explained that not only promiscuous kissing but promiscuous hand-shaking is a dangerous practice during respiratory epidemics. The hand of a sufferer is shaken. The doodler fingers his nose, mouth, or face. He infects himself with the cold virus as effectively as if he had embraced persons with acute coryza.

Indirect contact is a harder idea to get across to most people. They fail to see how the handling of contaminated objects influences them. The details about dishes, linen, clothing, and bed linen need not be emphasized. They are potent spreaders of all respiratory infections.

Mediate infection: Until recent times the idea of air-borne contagion suffered one of those medical lapses which sometimes occurs. After Pasteur had disproved the idea of spon-

---

Dr. Feasby, who practises his profession in Toronto, gave this paper at a refresher course, sponsored by the Central Registry of Graduate Nurses in Toronto.

taneous generation, it was almost forgotten that infection may travel through the air and that contamination may occur in this way or, as it is called, by mediate agents.

We now know that about half of all infections may occur in this way. Even when the most stringent care is taken to avoid direct or indirect contact, patients in a children's hospital may develop a communicable disease. Many a good nurse has been reprimanded by her supervisor because a cross-infection had been produced through lack of technique, as it was called. An incident in a Philadelphia hospital proved for all time that airborne infection is the real thing. Some children on the top floor of the hospital were in for scarlet fever. In a lower floor were some children with whooping cough. The nurses and doctors attending them happened to be entirely separate. All possible interchange of contact was excluded. The children on the top floor got whooping cough through the ventilating shaft which brought contaminated air through to their floor from the whooping cough ward. Hundreds of experiments have since shown that cross-infection in hospitals occurs in this manner. Dry dust will keep the hemolytic streptococcus alive for months. When it is agitated it floats about the room and settles by chance. If this place happens to be the respiratory tract, and if there is no resistance to this organism, the individual will develop an appropriate disease. It is known that this is true for bacterial diseases; it is not known that it has any significance in the virus diseases.

Special Etiological Agents

B. Hemolytic Streptococci: These are by far the commonest etiological agents in the period from December to June in this zone. They are also among the most serious because of the complications which may ensue in a high percentage of cases. Much has been learned about this group of organisms. There are more than sixty types. They have been identified by culturing and precipitating them against type specific sera. This method was developed by Griffiths in England and by Dorothy Lancefield in New York. The importance of knowing these types is so that epidemics can be traced from one locality to another, both inside and outside institutions.

Pneumococci: This group of organisms is not now so important as it was a few years ago. The advent of the sulfonamides and penicillin have reduced the mortality of pneumonia from this group of organisms from about 25 per cent to about 5 per cent. They still have to be reckoned with, of course, and there are about thirty or forty different serological types of these. Each produces a pneumonia which is clinically indistinguishable but it is known that certain types are more serious than others. Some of the higher types are not pathogenic for human beings.

Staphylococci: These organisms are not very important as causes of acute respiratory infections but when they are present they are very serious. Staphylococcal pneumonia is a very grave disease, or was, until penicillin came along.

Viruses: The common cold virus has not been identified. It is hoped with the aid of the electron microscope that something may be learned about it, but as yet no one has been able to isolate a specific etiological agent in spite of the thousands of attempts.

Influenza: There are several types of influenza virus. They are all capable of producing an acute illness which fortunately at the moment is not very fatal. These viruses may produce highly fatal epidemics from time to time. It is amazing that none occurred during the war. It adds credence to the view that in the first world war the influenza was the initiating disease but it was followed by other bacterial diseases which were the really fatal agents. Opportunities were found during the war to study the causes and types of influenza. With animal experiments using ferrets, and with test-tube methods in which precipitation and agglutination were

used, it was possible to identify two main types of influenza virus. These are influenza A and influenza B. Other unknown types can produce an almost identical clinical illness.

The Common Cold

Everyone feels competent to diagnose the common cold. That irritating malady which comes on at any time of the year, but which is more common during our winter, usually begins with sneezing, running nose, reddened eyes, slight elevation of temperature and pulse. Its course is about two weeks. Its complications are probably nil. Forms of treatment are legion. From the whisky and lemon stage, to the cold syrups, heating pads, hot water bottles, diathermy treatments, in every direction the methods of therapy extend in an ever-increasing array of worthless remedies. Every person has his own pet remedy — none of them makes the slightest difference to the course of the disease. Some of them make the disease worse or produce a worse condition. The best example of this is seen when an individual prescribes sulfadiazine for himself and develops an anuria and dies.

The only forms of treatment which are helpful are those which make the individual feel better. It should be realized that any form of therapy only alleviates the misery. One positive thing can be done. The individual should try not to give it to others. He should stay out of circulation. He should use all the usual methods of personal hygiene. He should rest more and avoid chilling so that no other bacterial disease will overtake him.

B. Hemolytic Streptococcal Infection

This group of diseases is not easy to recognize. They are easily confused with the common cold. The only really satisfactory way to distinguish them is to have a throat culture which must be properly made to be of value. The swabbing must be done from an area in which there is marked redness or exudate. There must be enough to keep the swab moist until it reaches the laboratory. The finding of streptococci is indicative but not positive evidence that the individual is suffering an acute upper respiratory infection. Some people have them in their throats at all times. They are a real menace.

When a patient is seen who was feeling quite well the day before, and who has now developed a high fever, perhaps up to 104° F. by mouth, and whose throat is sore beyond the degree of redness, and where there may be a little exudate over the tonsils or on the throat, this type of infection should be suspected. Prompt measures must be taken if the complications are to be avoided. These measures include absolute bed rest, plenty of fluids and protein, gargles or throat irrigation, and anti-pyretic drugs. There is generally a drop of the temperature by lysis during the next three or four days. The patient's throat develops an exudate and gradually becomes more sore and swollen. Following this, gradual resolution takes place. Much argument exists as to whether to use sulfa drugs or not to use them. They should not be used unless there is evidence of a complication. Experience has shown that they do not accelerate the healing of this kind of infection of the throat, that they do not prevent complications, and that one is, therefore, subjecting the patients to the risks of sulfonamide therapy unnecessarily in such cases. As for using sulfonamides without proper laboratory aids, it can be stated that this practice is dangerous in the extreme. This is done every day. The same statements apply in general to penicillin therapy. Until the infection shows signs of invading new tissues or forming an abscess, it is unwise and unnecessary to give specific therapy. The patients' own immunity reactions and resistance should take care of the disease in most instances.

Complications

The most serious part of a streptococcal infection is its possible com-

plications. About one-third of patients have some form of complication so special comment will be made on these.

Otitis media is perhaps the commonest. It develops about the fourth or fifth day, manifests itself by rising temperature and pulse rate, and by the classical earache. Quick action is often necessary to avoid perforation of the drum — a competent otolaryngologist should see such ears early. This is a place where sulfonamide or penicillin therapy may avert disaster. Some times, of course, paracentesis of the drum is necessary. The development of mastoiditis is an uncommon complication nowadays.

Spread to other parts of the upper respiratory tract accounts for another 5 per cent of complications. These include trachitis, laryngitis, sinusitis, and acute infections of the tonsils and surrounding lymphoid tissue.

Streptococcal pneumonia: In some epidemics of streptococcal infection the development of pneumonia is a major difficulty. These constitute serious medical emergencies and require prompt medical treatment if life is to be saved. They manifest themselves about the seventh day of the illness by sharp rise in temperature and the development of bright red sputum. There is sometimes a pleurisy and then the classical course of a consolidating pneumonia. The sulfonamide treatment or penicillin therapy is almost always successful in bringing about a favorable outcome.

Adenitis develops in about 2 per cent of patients with streptococcal illness. It may be followed by suppuration but this can usually be prevented by the adequate and proper use of sulfonamides.

Acute nephritis develops in about 1 per cent of this group of patients. It is a serious disease which carries a high rate of invalidism and an earlier date of death than that predicted for the general population. Its development occurs about six weeks after the sore throat is over. Increasing fatigue, smoky urine, even the passing of blood may herald its arrival. Unless the patient is warned and is on the lookout, this may pass unnoticed and no warning of the impending doom is seen until the patient develops edema and has a urine which boils solid with albumin. The treatment of acute nephritis is classical and consists mainly in diet and rest. It is worth noting that the development of an artificial kidney can save some of these cases in the first acute uremic stage.

Unusual skin rashes: About the sixth week after some streptococcal infections there develop queer skin rashes. These rashes have names like erythema marginatum and erythema multiforme but are usually mistaken for something worse. Occasionally they are confused with trench mouth for there may be an ulcerative, exfoliative lesion of the mouth at the same time. They should be kept in mind toward the end of the streptococcal season in May and June.

Febrile polyarthritis: During the war there was evidence of a new disease. Troops stationed in areas where there was much of the *B. Hemolytic Streptococcus* infection developed many cases of acute swelling of the joints. At first it was thought that this differed from classical rheumatic fever. It did only in one respect. The cases were grouped and followed sufficiently closely upon the heels of the streptococcal epidemics to be recognized as being clearly related to this infection. Some studies made on a large scale in 1943 at Camp Borden showed that about 1 per cent of those suffering an acute streptococcal infection developed joint signs. These men had an incidence of about one-third heart lesions. Some of them will be dead already. Many of the heart cases are limited and invalided. The cost to the country in pensions is amazing. The cost to the individual is sickening. The incidence of rheumatic fever can only be lessened by reducing the severity of the rheumatic infection, and eventually by eradicating the disease entirely. It is perhaps the most serious of all complications.

Pneumonia

There is not nearly as high a mortality from pneumonia today as there was a decade ago but it is still an important disease. The two main types are, of course, lobar and bronchial. Lobar pneumonia can be dismissed briefly. It is rarely seen today but still occasionally occurs. The only hope of the patient used to be a good nurse. Now he has the assistance also of penicillin and the sulfonamides. Complications such as empyema and abscess still occur but rarely.

Atypical pneumonia is now a better name for the bronchial type. Early in World War II there arose an increased interest in this disease because it affected such a large group of troops that the profession suddenly became aware of its existence. It begins often with a hard hacking cough and some blood spitting. When this is seen the first thought is tuberculosis. It continues a febrile course which may or may not confine persons to bed. About a quarter of them continue to walk around. There is not much tendency to complications but during such epidemics there is more pleurisy with effusion than usual. This makes diagnosis more difficult because care must be exercised to exclude pulmonary tuberculosis as a cause of this effusion. There is not much treatment which is of value. Rest and fluids and a high protein diet are about the best that can be offered. The sulfonamides and penicillin are positively dangerous unless a bacterial invasion has also occurred.

Steven Johnson disease or mucosal respiratory syndrome: In this rare disease the individual usually develops a pink eye, then scabs in the nose or lips, then ulcers of the mouth, the vagina or in the urethra and then a pneumonitis. Various forms of antiseptic treatment are used but they are all quite useless. Death ensues in about 70 per cent of cases and it is a most unpleasant one. Skin lesions are also sometimes a feature with hemorrhagic bullae all over the body. The patient wastes and fails because the gastro-intestinal mucosa has a similar number of bullae to all other mucosal surfaces. A few recover and are then apparently well.

Treatment

The sulfonamides are prescribed by the thousand of tablets every day for acute respiratory infections. It is not believed by those who are most honest about this form of therapy that it does very much good. In the case of streptococcal infection it is useful only when an invasive, progressive lesion with pus formation is going on. Thus an acute sore throat or a patient with scarlet fever gets better just as fast with gargles and an anti-pyretic as he does with sulfonamide drug. When an otitis develops or an abscess forms around a tonsil, the sulfonamide therapy should be tried promptly, in large doses, with proper blood and urine control and the administration of proper amounts of fluid. Why is it dangerous to dish out sulfa pills like baking soda? It is known that people die and develop organisms which cannot be controlled because of the good drugs squandered on them when they did not really need them. The same arguments apply to the use of penicillin. It is known that it is good for pneumococcal pneumonia and for some streptococcal conditions. It is best for the rare staphylococcal pneumonias. It is dangerous to use on common colds and sore throats. The incidence of skin manifestations with possible exfoliative dermatitis is said by some skin experts to be as high as 15 per cent. Why expose people unnecessarily to this? It was a great relief to the profession when penicillin was taken off the open market.

The nursing aspect of acute infections is extremely important. Almost the only chance a patient has with some of these conditions is to be well nursed. In the case of the last disease mentioned, it is the only chance. The essentials are to keep the patient warm, dry, clean, and resting. The room should have moist air. The precautions about asepsis cannot be overdone. Air the room four or five times in twenty-four hours.

You can dilute the bacteria even if you cannot keep them all dead or dying. Dust everything with an oiled mop and cloth every day. It protects you and the patient's visitors better than any other single method. Watch personal hygiene very carefully. Be a faddist about washing hands and face.

Summary

To summarize, consider any city of a hundred thousand on any winter day in Canada, from November to April. This is the season for widespread epidemics of respiratory disease in the temperate zone and produces, through the various diseases described, a situation like the following. Ten thousand people are sick or are becoming sick. Two thousand of these are in bed at home or in hospital. They will lose collectively not less than thirty thousand days from work, thus reducing the potential national labor effort. The amount of personal income lost by this wastage of working time cannot be estimated accurately, but if each individual lost five dollars a day it would result in a loss of one hundred and fifty thousand dollars. Of all these persons who are ill, fifty will be disabled in varying degrees some time during the next six months; many of them will never be competent wage earners again. Of the group who fell ill today, five will be dead within six months, perhaps two of them in a much shorter period.

To compute the losses in a great metropolitan area for a given day, you simply multiply the figures by the appropriate factor to arrive at the wastage. It should be noted that the figures given were the total number of sick on any given day. Alterations in the computations are necessary for a day-to-day analysis which will bring about an estimate of the amount of time wasted per month and per year. To give one example of such computation, it is no exaggeration to say that not less than ten million dollars of earning power are lost each year in Canada as a result of acute respiratory illness.

A survey of the time wasted and the money lost, not to mention the human suffering involved, is impressive. Because this scourge is so close to us, very few people attempt to do anything about it. Perhaps those who grasp the thoughts concerning the incidence and control of acute respiratory disease will become powerful educators who will gradually change this shocking story. It need only be remembered that acute respiratory disease can be reduced if two main lines of prevention are followed. The first of these is the improvement of personal hygiene; to reduce the amount of droplet, direct, and indirect spread of the etiological agents. The second of these lines is to prevent the transmission of infected droplets and bacteria by mediate infection, in the clouds of letho-infected dust which surround our people wherever they go in the winter months in the so-called temperate zones. In the home, careful housekeeping, including removal of dust, oil sweeping and dusting, is extremely important. In public places these measures assume greater importance but to date have had inadequate attention. Repeated demonstrations have shown that respiratory disease can be reduced by such measures by as much as 50 per cent. It is worthwhile to apply these measures to alleviate the greatest single scourge peculiar to the temperate zones.

Typhus Fever

Typhus fever, which cost millions of lives in Eastern Europe during and after World War I, and which threatened to become a major problem in the recent war, was checked even in wartime in the areas under the control of the Western military powers. There has been only a moderate rise in typhus incidence since the close of the war and this is limited to the usual endemic areas of the disease, such as Rumania, Bulgaria, and Hungary.

The Block System of Nurse Education

N. Street

Explanation of the Term

Many of you probably know what is implied by the words "block system," but for the benefit of those who may not yet be familiar with it the block plan of instruction is an arrangement of alternating classroom work and ward practice. Instead of the usual method of working on the wards at the same time as classes are being held, the student is taken off duty completely and given classroom study only for the period of time necessary to complete her year's theory. The student thus covers, in a concentrated period of time, usually six to eight weeks, the studies which would otherwise extend over a period of approximately ten months.

Organization

The usual pre-clinical period of four months for new students is carried on with few changes. In the description of the block plan of instruction in the *American Journal of Nursing*, December, 1946, Mary Shepherd writes of the pre-clinical students taking their initial clinical courses, given in the first year, immediately after capping time, with sixteen hours of weekly ward practice. At Holy Cross Hospital in Calgary we think that the nurses derive a greater benefit from the first-year subjects if they are assigned to medical-surgical wards for at least two or three months before taking their initial clinical courses. At the beginning of the second year, the students enter eight weeks of concentrated study. The courses offered at this time include: psychology, ethics, obstetrics, pediatrics, and the various clinical specialties.

A third class period of four weeks is placed also in the senior year, when the remainder of the clinical courses are given. The block plan of instruction is fairly flexible and can be adapted to the different situations found in various schools of nursing.

In order to give you a clearer picture of the rotation of the block, I will summarize it as follows:

From August to January we teach successively half of the junior, intermediate, and senior nurses. From January to May we repeat the same courses for the other half, this time taking the intermediates, seniors, and juniors, in that order. As Holy Cross accepts nurses twice a year, the groups taking classes after January are the groups who have entered in the spring, thus facilitating the rotation of the block and making it possible for the nurses to receive their period of instruction at the beginning of their second and third years.

Doctors' Co-operation

As the doctors do a considerable part of the classroom teaching and also because they have to give classes daily until their course is completed, it is necessary to have the doctors' co-operation. In order to gain their co-operation, before starting the block system in our school the faculty had a few meetings with the chiefs of the various clinical departments to discuss the possibilities of such a system. The doctors promised full support and it is gratifying to say that they have been most enthusiastic and seem to prefer the new methods to the old.

Necessity for Clinical Program

Objections have been raised to this plan, and rightly so, on the grounds that students readily forget theory taught in the classroom, particularly when away from actual study for the greater part of the year. A clinical teaching program is, therefore, a necessity with the block system and much effort has been expended at the Holy Cross in perfecting the ward teaching program for students assigned to practice between class periods. Ward conferences, doctors' clinics,

Mrs. Street is instructor of nurses at Holy Cross Hospital, Calgary, Alta.

bedside teaching, and nursing care studies are planned with such care. Each student keeps careful record of her ward teaching. There is constant need for more emphasis on this phase of the program for this is the only means of effective correlation between classroom and nursing practice.

Evaluation of Benefits

1. There is a continuity in the classes which was not possible when a subject was taught perhaps once a week over a period of many weeks. Consequently, there is greater interest in a subject, both for the instructor and the student.

2. Class grades are better, as students are not fatigued and worried by ward duty when coming to class. It is easier for them to concentrate and they are ready to listen, to think, and to learn.

3. Nursing service is made more stable than it can be when students are continually leaving the wards to attend classes.

4. A more logical rotation can be planned as each student may be sent to various departments for practice after having concluded her block of theory.

5. Students like it. Their greater interest and attentiveness at classes are proof of this.

6. There is less illness among the students. Perhaps the complete change from wards to classroom is restful in itself. Certainly they are not too tired to study and get adequate rest.

Disadvantages and Difficulties

1. Correlation between classes and practice may be incomplete unless there is a strong ward teaching program.

2. The class program is more concentrated, therefore heavier for the student and instructor.

3. Unexpected cancellations of doctors' lectures can be disconcerting because classes must be completed in a given time.

4. The ward average is depleted, therefore more student and graduate help is required.

5. It is more expensive for the hospital.

The ward depletion may be overcome to some extent by dividing each class into two groups, as we do at Holy Cross, for the purpose of instruction.

In closing, I would like to say that we do prefer the block system at Holy Cross. By we, I mean, supervisors as well as instructors. The first few months were very trying, especially for the supervisors, as we had to add a large number of general duty nurses to our staff and as they were helping only for a month at a time the nursing service was very unstable. Now that we have more students and the graduate staff is more stable we feel that the block system is more advantageous, even to the patient.

"Study Days" for Nurses in Training

May Marshall

The adoption of the "study days" program for student nurses in Britain's hospitals is a comparatively new venture and up to the early months of 1948 it was in full swing in only a minority of training schools, but it is a scheme which has provoked great discussion and interest. The hospitals which have adopted the scheme are enthusiastic about its efficacy and their examination results justify their enthusiasm.

The scheme may be said to be a

Miss Marshall is associate editor of the *Nursing Mirror* (London).

compromise between the old, and now vehemently denounced, method of expecting a student nurse to attend lectures and pursue her private study in her off-duty time, and the more modern method of training under the block system. Those who favor the "study days" program assert that it proves less disrupting than the block system, in that it does not entail the sudden departure of a whole section of students *en bloc* from one particular department. It might seem that the "study days" scheme would also be disruptive, since it demands that during her course of study a student nurse is absent from the wards or other practical departments for two consecutive days each week — her study day and her off-duty day. But the scheme is proving workable where there is a full quota of students of each year in training. They have different study days and so are not absent simultaneously from the practical side of the work. The basic fact remains that where a hospital provides first-class training there is — even in these days of clamor about shortage of nurses — a full quota of students and usually a queue of would-be trainees, hopefully waiting to be accepted "on the strength."

Let us see how the scheme works in two typical hospitals where it has proved its success — a London hospital and a provincial hospital. First, there is the London Hospital — one of the most famous training schools for nurses in the United Kingdom, whose certificate is acknowledged as "the sign of a good nurse" the world over. Here the program works with the ease of a well-oiled machine and the matron and all her sister tutors are full of enthusiasm for it (and remember that the standards of the London Hospital are pinnacle-high).

On successful emergence from the preliminary training, the student nurse enters hospital and will have fifty-two study days in the course of her training: sixteen days in her first, second, and third year's course respectively and four days in preparation for the final state examination. The study days, arranged in courses, occur weekly and are followed immediately by the student's off-duty days. The day begins at 9:00 a.m. and ends at 4:30 p.m. with a quarter-of-an-hour's break for mid-morning refreshment and one-and-a-quarter hours for midday dinner. The day's schedule, according to the year of training, includes in the whole course of training: lectures by doctors, sister tutors, dietitians, radiotherapists, and other specialists; time for private study; clinical lectures and demonstrations; practical demonstrations and visits to the various technical departments of the hospital and places of relevant interest, such as tuberculosis settlements, maternity and child welfare centres, and so on.

Smooth running is ensured by this method of allocation: while first-year students have Monday as a study day and Tuesday as a day off, second-year students take Friday as a study day and Saturday as their day-off. Third-year students are provided with Wednesday as a study day and Thursday is their day off. Each course of study days is held twice a year, beginning in March and September, so that only half of the nurses in training are attending in any one week — obviously an efficient arrangement.

One striking feature about the successful organization of this scheme at the London Hospital is worth consideration. When the scheme was first worked out in detail, the matron and her administrative staff decided it was desirable, but not workable with the present minimum nursing staff, if the nurses adopted the 48-hour week. It was a question of either reducing the working week or the "study days" scheme — and the latter won (a point worth emphasizing to all cynics inclined to say glibly that the "modern girl wants only a soft job!").

Now to consider the program as carried out in a provincial hospital — the Southend-on-Sea General Hospital. Fundamentally, it is worked on the same lines as that of the London Hospital, except that the student's day off precedes, instead of follows, her study day. Her place when attending a study day is taken by a relief

nurse, who wears the letter "R" on her sleeve. Thus, with eight relief nurses and four study days a week, thirty-two student nurses can have a weekly study day.

First-year students have two periods of study days, each for from six to eight weeks, according to the nurses' needs. Second and third-year students each have three study periods of eight weeks and clinical classes between such periods as and when interesting cases come into the wards.

The study day begins at 10:30 a.m. to allow students who may have slept out on their off-duty time to reach hospital: 10:30 a.m. – 12:30 noon, lectures; 12:30–1:30 p.m., dinner and break; 1:30–2:00 p.m., study; 2:00–4:30 p.m., demonstrations and clinical discussions; 4:30–5:00 p.m., tea; 5:00 p.m., one hour's test paper on the previous week's work; 6:00–8:00 p.m., private study.

Sister tutors, ward sisters, and students alike acclaim the advantages of the scheme at this hospital, for it is obvious that a student who comes fresh to lectures and books is better able to grasp what she is being taught. It may well be that the future will see more and more of Britain's hospitals organizing the "study days" program in their training schedule, adapting it cleverly to the individual needs of each hospital.

Boot Straps

ANNE SIMSON-RATHBONE

LOOK BACK fifty, seventy-five years. Sairey had gone but the shadow of her umbrella had not yet passed. If, at the age of twenty, you had set a determined face toward the life of a nurse, your family would have taken a dim view of the plan; your aunt might have hinted delicately that you were doing something not quite nice. Your other aunt might have thrown out vague conjectures anent the reprehensible morals of hospital doctors.

However, you pushed on. With the turn of the century came Marconi and the Wright brothers, accompanied by horseless carriages and electric streetcars. Suddenly the world speeded up. The shadow was gone — gone from you and the whole field of nursing. The public gave you its respect and support, even its deference. The uniform of a "trained nurse" was tacitly inviolate. Your field, though narrow and with long hours of work, was honored and secure. For years this happy state of affairs continued. Sociologists even began to think that people were actually becoming civilized. But 1914 brought war. Soldiers, sailors, airmen, and nurses were followed by aides, ambulance drivers, entertainers, canteen workers, Red Cross, the Society of Friends — all wearing uniforms and developing that appetite for them which, later, was to give rise to the condition of today, whereby salesgirls behind food counters, the assistants to optometrists, specialists in beauty parlors, and packers in canneries are outwardly the exact replicas of nurses. There is nothing whatever wrong with this; for sanitation and public health it is very right. But few moderns realize the extent to which a nurse's uniform was once sacrosanct; how that subjective appeal to the romantic soul of a teenager was the attraction which first caught the eye and the interest of those who, later, were to send applications to training schools and finally to develop into fine nurses. Is there any

From the eminence of many decades as a graduate nurse, Miss Rathbone offers some suggestions to present-day nurses on pulling ourselves up by our own "boot straps." When she retired from active nursing many years ago, Miss Rathbone established her home at Gibsons, B.C.

way in which we can restore that value, both for practical and for psychological reasons?

Populations are largely made up of unthinking masses of humanity. Even in Canada today, a surprising number of people accept professional claims on slight surface evidence, and with incredible carelessness regarding the checking of deeper credentials. But certain callings more than others require an outstanding uniform and the role of a nurse is an extremely important one. While on duty she should be instantly recognizable from, say, a lady barber.

Meanwhile this whirling world is pitching us willy-nilly into internationalism, and before we get our breath it may, in truth, suddenly have become one world. However that may happen, through war or by peaceful means, the ever-quickening tempo and ease of travel will see the graduate nurse more frequently over the whole earth.

If one studies an unabridged life of Florence Nightingale, her comprehension of military matters and the affectionate honor in which she held religious sisterhoods, one gets an impression that the field of nursing was fathered by the army and mothered by the church. So we have a double heredity right to a special, distinctive uniform. In the fighting services each individual wears a foundation suit of a defined color and cut. Additional details of headgear, stripes, belts, bands, badges, and buttons are used to indicate rank and other differences. Such insignia also lend themselves to the furtherance of that personal human interest which helps towards understanding and co-operation. Conversely, a nun's vestments are marked by extreme conservatism and by great simplicity.

The consideration of an all-world uniform for nurses needs immediate attention. It would require time and thought and work by our international leaders, and would need to be buttressed by some kind of global agreement. Such prominent features of the two systems mentioned as fulfilling the needs of nurses could be incorporated into a costume, easily and quickly put on and off, adaptable to various emergencies and climates at home and abroad — a basic dress of color and cut to denote any particular brand of service, also some distinguishing marks of rank, etc. Insignia convey facts, a story that is told; they are necessary. But for everyday use they should be few, and be calculated to arrest attention by their simplicity of design, to be noted and remembered. Confusion in the mind of the beholder is to be avoided or we defeat our own ends; for special occasions and for dress uniform, full regalia are in order. Taking a hint from the dress of nuns this universal uniform, once adopted, should not easily be abandoned nor subjected to fickle change. Then, come war, come pestilence, in that respect we shall be ready.

Regarding another matter: It is not solely within the field of nursing that conditions daily become more chaotic. That particular field, however, is *our* concern. It is *we* who must attend to that. Personally we believe that the whole system of dealing with national health should be revised, that curricula of nursing schools and medical schools should be integrated. If this could be accomplished, there would immediately be an improvement in the number and the quality of school of nursing applicants. But it could be accomplished only by a long pull, a strong pull, and a pull all together, under the leadership of experienced and tactful organizers. Prophylaxis throughout the country would be dovetailed with the services of curative institutions, regular and enforced check-ups with the work of clinics and hospitals; and the whole would be systematized.

With our present demand for more nurses, with the lost year between high school and training school, with the perplexing problem of too few satisfactory applications, with ward assistants coming in and going out of hospitals, often leaving minus credentials, and with an indiscriminating public, there is grave danger of falling into confusion, even into a state of rever-

sion; a loss of much that has been gained in eighty-odd years; a risk of a return of Sarah Gamps, twentieth-century model — trim, well-groomed, and lip-sticked.

Outside of hospitals, as has always been the case inside, there should be a well-recognized gradation of nurses: practical nurses, two-year course nurses whom many physicians are demanding for their private practice, three-year graduates, graduates with university diplomas — and physicians. By propaganda the public should be educated to understand differences and to distinguish the various insignia.

Against the idea of nurses progressing to the rank of physicians, it may be urged that the same person should not undertake both the ordering and the administration of drugs and treatments. That is true. But no change in that axiom would be indicated; there always would be grade nurses or ordinary help in homes to carry out doctors' directions, exactly as at present.

It is said that women are not strong enough, physically and emotionally, to take their places with male doctors. That also may be true. However, there are now many branches of medicine — and there will be still more when state medicine is established — where they should be able to take a very satisfying part — in institutions, all-office practice, insurance examinations and examinations for employment, regular check-up routines, etc.

Certainly as a doctor, she will have lost nothing from her training as a nurse, but will be all the more competent in many fields of diagnosis and treatment from the habit of observation gained in practising massage in many, many types of cases, from having given many, many baths, from having assisted many, many patients in their efforts to walk across floors, from having given many, many enemas, from having emptied many, many bed-pans, and knowing the results of many, many diseases.

A word to student nurses: Your life has been thrust into an era absolutely new in world history — an age of ready-madeness, standardization, mass production, of gadgets galore to help you to avoid thought and inconvenience. Even in public schools, where formerly there was no royal road to learning, there is now a smoothed highway. Through a medium of excessive reiteration even *thought* and *opinion* fall into the line of least resistance. During your years of training it will be difficult but richly satisfying if you can manage daily to get a little time to withdraw and be alone. Shape your life towards definite purposes. Learn to discriminate between what is lasting and important and what is a passing, present detail. In your clubs and councils, fundamental matters should not be presented and emotionally voted upon at the same meeting; demand time for reflection. We women as a class, and nurses particularly, are slackly deficient in understanding of political issues, and we sail along on catchwords. It may take strength of mind to cultivate an interest in public affairs, but at least we can have enough patriotism to listen to good news broadcasts. Beware of depending on governmental handouts to the profession. A spoon-fed population turns sharply in the opposite direction from evolution.

You are forming plans for the future. Into that prospectus will you not single out one definite thing to do for Canada? What can a young girl do? Do you remember in our history the great pioneer work done by nurses in Quebec? That pioneering is still unfinished. In our northland, Canada has her most momentous problem. Hungry eyes outside are appraising it; vast emptiness and riches make it vulnerable in a military sense; moreover a part of our duty there is to make restitution for the white man's neglect of our native Indians. Nothing adequate has been done for them to build up resistance to the diseases we introduced. As for general education, they have not got the vote because they are illiterate, and they are illiterate because they have not got the vote. They daily grow more conscious of our selfishness, more ready to fall a prey to subversive in-

fluences. Instead of their fine qualities having been developed and welded into the common life of the nation, they may even become a heavy liability.

If every young graduate would resolve to spend one year at a stipulated salary, with reasonably comfortable living conditions, in a hospital at a northern outpost, the result would be heartening; immediately with the assurance of a supply of *bona fide* nurses, hospitals would spring up to care for the health of the Indians and our nation builders.

And do not forget that it is a young man's country. Young women, too, are needed and wanted there. Do please have the imagination to get away from cities. New Canadian homes and families are needed in the north. Good luck to you all!

Rotation of Students

SISTER FRANÇOISE DE CHANTAL, S.G.C., B.Sc.

THE FOLLOWING is a description of the pattern for the education of our student nurses carried out at the University of Ottawa School of Nursing for the year 1947-48. Practice is secured at the Ottawa General Hospital.

Our objective is to guide and direct the student toward the fullest development of mental, physical, spiritual, moral, cultural, and religious qualities as related to the scientific (knowledge), artistic (skill), and spiritual (ideals) aspects of nursing. Every effort is made to imbue the student nurse with a thorough appreciation of her obligations and responsibilities and to instil in her the high essential ideals of a Christian nurse. For this reason, the nurses are given courses in religion and ethics, so as to achieve our objective through our philosophy of life and religious faith which are characteristics of a Catholic institution. Its philosophy and religious principles will guarantee to all its students the effective and persistent adherence to the most exacting ideals in the professional life.

The professional objective is to help the student to acquire the knowledge, attitudes, and skills required for professional nursing service in the hospitals as well as in the homes, for health teaching and participation in organized programs for the prevention of disease and the promotion of health.

The educational objective is to offer to young women wishing to become professional nurses a basic education in the art and science of nursing. The rotation is thus planned to serve as a guide to faculty and students in carrying the educational purposes of the school. It is being worked out for each student one year in advance and is strictly adhered to. The students are changed from ward to ward within the departments by the supervisor in charge of each department. The rotation is set up on a weekly basis and changes are always made on Monday morning. The accompanying graph illustrates how our rotation program worked for the year 1947-48.

Students are admitted once a year. For the period under review, the class was registered on August 29, 1947, followed by a three-day orientation period.

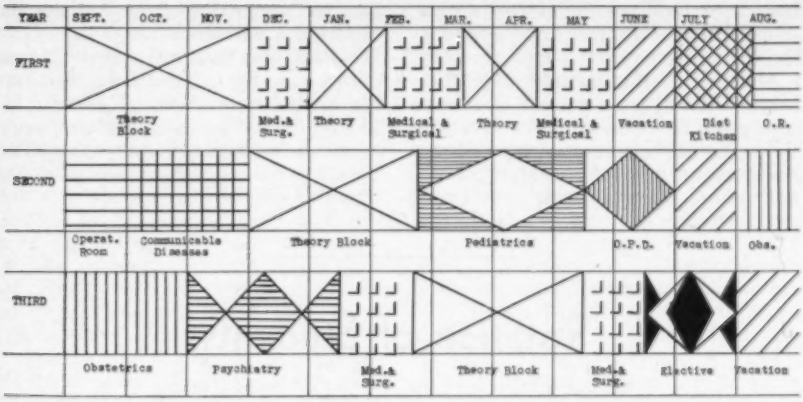
The curriculum is developed on a collegiate level and is of a professional rather than a strictly technical type.

The placement of the theoretical and clinical courses in the program of studies and their correlation with each other secures unity and continuity in the whole program. It provides for a steady progression from simple to complex experience in the student's

---

Sister de Chantal is director of undergraduates at the University of Ottawa School of Nursing.

Rotation Program



preparation, and a balanced distribution of the learning load with the least overcrowding and overlapping. The theory precedes the practice.

The time devoted to clinical practice as well as to classroom work covers eight hours a day and a six-day week. While in classroom the students are free Saturday afternoon and Sunday.

The preliminary term covers three months of classes starting the first of September. It includes the basic subjects which are being used throughout the course.

FIRST TERM

	Hours per week	*Total hours*
Religion	2	24
Anatomy	4	48
Bacteriology	2	24
Chemistry	4	48
Physiology	4	48
Materia medica	1	12
Nursing arts	5	60
Hygiene	1	12
Psychology	2	24
	25	300

On December 1, the students are given a straight eight-hour day experience on medical and surgical wards for one month. They return to university for the second term of five weeks, followed by clinical experience, and a third term of five weeks completes the first year theoretical work. The reason for the second and third term is our bilingual course. While the English group attends university, the French part of the class has clinical experience and vice versa.

SECOND TERM

	Hours per week	*Total hours*
Dietetics	6	30
Pharmacology	2	10
Pathology	2	10
Nursing arts	3	15
Psychology	2	10
Medicine	2	10
Surgery	3	15
Pediatrics	2	10
Professional adjustments	1	5
	23	115

THIRD TERM

	Hours per week	*Total hours*
Pharmacology	2	10
Dietetics	6	30
Medicine	3	15
Surgery	2	10
Pediatrics	2	10
Psychology	2	10
Nursing arts	4	20
History of nursing	2	10
Professional adjustments	1	5
	24	120

A five-week term in diet kitchen, as

well as medical and surgical experience, is given to first-year students. Operating-room technique of eight weeks' duration is started toward the end of the first year, followed by affiliation in communicable diseases. A four-week vacation is given to each student in each year of the course.

The theory block of twelve weeks in the second year extends from December 1 till February 23. This includes ten weeks of regular class, one week of Christmas vacation, and one week of final examinations. The second year's theory block being completed, the students are now equipped for specialized departments such as: pediatrics, out-patients, obstetrics, psychiatric affiliation, and advanced medical and surgical experience.

SECOND YEAR

	Hours per week	*Total hours*
Religion	2	20
Advanced surgery	2	20
Advanced medicine	2	20
Study of special drugs	1	10
Communicable diseases	2	15
Advanced pediatrics	3	30
Gynecology	3	30
Obstetrics	3	30
Mental hygiene	2	20
Ethics	3	30
Orthopedics	2	20
Emergency nursing	1	10
Public health and health teaching	1	10
	27	265

The third year's theory block of twelve weeks starts on February 23 and ends on May 17 with one week of Easter vacation, one week of final examinations. The advanced medical and surgical experience is completed and elective departments are chosen by the student with the advice of the guidance counsellor.

The methods of teaching used include class, lectures, ward clinics, medical conferences, films, maps, etc.

THIRD YEAR

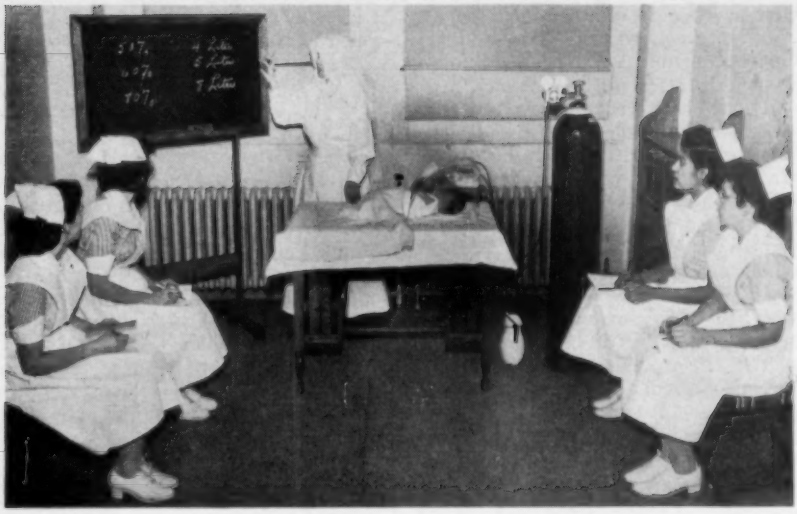
	Hours per week	*Total hours*
Religion	3	30
Tuberculosis	2	20
Venereal diseases	1	10
Urology	1	10
Psychiatry	3	30
Home nursing	2	20
Sociology	2	20
Professional guidance	1	10
Ethics	2	20
Eye, ear, nose and throat	2	20
Dermatology	1	10
	20	200

Pediatric Training, O.G.H.

SISTER RAYMOND DE MARIE, S.G.C.

This chart shows the rotation in the department so that a thorough knowledge and understanding of the entire ward is acquired.

Nurse's Name	*Dressings 2 weeks*	*Medications 2 weeks*	*Baby – Lab. 1 week*	*Nursery 4 weeks*	*Boys' Ward 2 weeks*	*Girls' Ward 2 weeks*	*Charting 2 weeks*



Instruction: Morning conferences are given daily from 7:30 a.m. to 8:00 a.m., alternating theory and demonstration. In the illustration is seen the position of the patient in the plastic oxygen tent, the proper literage used in gauging the oxygen being shown on the blackboard.

Baby laboratory: Each student nurse spends a week in the baby laboratory personally preparing feedings, thus acquiring a general knowledge of the composition of each formula, a thorough understanding of the importance of finding a suitable formula for each particular case, and an acquisition of the accuracy with which each formula has to be dealt.

These pictures tell the story of the training student nurses receive during a three-month stay in the pediatric department of the Ottawa General Hospital. Sister Raymond de Marie has described the program that the photos illustrate. See cover picture to complete the series.

Conference room: Supervisor and graduate nursing staff.

Dressing room: The first week the student works with a graduate nurse under supervision and instruction, while the second, she carries out treatments alone, with the assurance that there is always a graduate on hand to whom she may refer.

Pharmacy: The administration of medications facilitated by the Cardex Method.

Girls' ward: (Girls from one to twelve years of age.) Surgical and medical cases are mixed, the cubicles serving as a protection.

Charting: Due to the many items involved in making charts in pediatrics, each nurse in turn is assigned to do them for a period of two weeks. The nurse on the wards leaves a report of the daily happenings of each patient entrusted to her.

Supervision: Glass doors and glass partitions is the ideal layout for supervision without disturbing the student nurse.

Epilepsy

EDITH M. PULLAN

SUPERSTITION shrouded the condition of epilepsy from the ancient Hebrew and Greek civilizations to fairly recent years. Epilepsy has been described in ancient records as being caused by demons, devils, and spirits. It was known as "The Sacred Disease" by the Greeks. Martin Luther named it "The Demon Disease." Other names which have been attached to it are "the spitting disease" or "falling sickness." The more recent terminology has been epilepsy, but even this nomenclature is showing disfavor with the result that the term "cerebral dysrhythmia" is now being used by some who have made extensive studies. Because of the common use of the word "epilepsy," which is used to describe the occurrence of seizures, it will be referred to as such throughout this article.

Epilepsy is considered by many to be a definite disease entity, but on closer scrutiny it is found not to be a disease but a possible symptom of several disease conditions. It is characterized by an impairment of consciousness, with or without the presence of involuntary muscle movements, abnormal sensations, and psychic disturbances.

The causes which produce epilepsy may be divided, generally speaking, into two main groups. Forty per cent of all epilepsy is of organic origin and 60 per cent is of idiopathic origin (cause unknown but showing no definite organic origin). The etiological factors can be classified as follows:

Cerebral agenesis — failure in brain development.

Infections — e.g., neurosyphilis, encephalitis.

Tumors — primary and secondary.

Degenerative — e.g., cerebral arteriosclerosis.

Toxic — exogenous: e.g., chronic alcoholism, lead poisoning; endogenous: e.g., acute febrile diseases, kidney failure, eclampsia.

Trauma — e.g., birth injury, depressed skull fracture.

Endocrine disorders — e.g., hypoparathyroidism, hyperinsulinism.

Idiopathic — very few pathological factors are present but there is a heredity factor.

Induced — e.g., electro-shock and metrazol therapy.

Miss Pullan is instructor of nurses at the Provincial Mental Hospital, Essondale, B.C.

SEIZURE PATTERNS

There are certain seizure patterns which are characteristic of epilepsy.

Grand mal seizure: The grand mal seizure is the most spectacular and dramatic of all the various epileptic manifestations. Preceding the loss of consciousness there is a warning or aura, which lasts from an instant to several seconds. This has been described by patients as being a hallucinatory type of experience such as a bright flash of light, a peculiar gastric sensation, or a peculiar odor.

The loss of consciousness is accompanied by involuntary tonic and clonic contraction of muscles on both sides of the body. Often, with the onset of the muscle contractions, there is a cry which is peculiar to this condition and is known as the epileptic cry. Marked cyanosis is present in the tonic stage which is relieved when the clonic contractions have commenced. Also, during the tonic stage, the jaw is rigid and in a contracted state, which may bring about complications if the tongue should fall in the way of the teeth when the jaw is clamped shut by the tonicity of these muscles. The accompanying clonic stage is characterized by involuntary jerky movement of the muscles caused by alternating contraction and relaxation. There may be micturition and defecation resulting from the relaxation of the sphincter muscles. "Frothing at the mouth" may occur at this time, brought about by a churning of the saliva by the movements of the tongue.

A state of stupor and sleepiness

usually follows in the wake of a grand mal seizure, with a gradual return to consciousness. In most cases the patient is unaware of anything having happened to him. It is fairly common to have the patient complain of fatigue and headache. A state of partial disorientation may be present as an aftermath of a seizure.

Petit mal seizure: This is a state where the patient loses consciousness, but it is not accompanied by muscular spasms. It will be noted that the patient stares and that his attention cannot be secured. He may momentarily suspend his occupation or drop whatever is in his hand. After a few seconds he will return to consciousness and continue with his activities as if nothing had happened. Very slight muscular twitchings may be present at this time.

Jacksonian seizure: In this form of seizure there is retention of consciousness, accompanied by a twitching or jerking movement of confined groups of muscles, i.e., in the arm or in the leg. It may spread to all of one side of the body, in which case there is a loss of consciousness. This type of seizure is an indication that the attack arises from a certain section of the brain, the cause of which may be due to scar tissue or to the presence of a tumor in the area of the brain controlling the muscles affected.

Psychic seizure: Psychic equivalent or epileptic equivalent is more difficult to define, because the actions of the patient are more diverse than in the grand mal seizure. The patient does not completely lose consciousness and consequent control of himself but is overwhelmed by a state of amnesia, during which he acts as if he were conscious. He may walk about, mumble, and go through certain actions. This attack may last only a few minutes or may continue for hours. It is possible for a person in this state to become resistant if any attempt is made to restrain him. Furthermore, he may show signs of belligerence and combativeness toward his opposer. Occasionally he may commit a crime during the seizure. Tonic spasms may be present but clonic spasms rarely occur.

Persons who suffer from epileptic seizures may lead a fairly normal life if their seizures are controlled. On the other hand, there are some who develop a psychosis or who develop what is termed an epileptic personality. Those who do show such a change display the following characteristics in varying degrees. They show egocentricity, a shallow interest in others, and religious sentimentality. They are very susceptible to flattery and are eager for praise. There is lack of initiative and interest in their environment and appearance. Boasting is quite common. Emotional changes, with marked irritability, childishness, and obsequious behavior are accompanied by paranoidal trends.

Treatment

If physical signs are present it may be possible to remove the cause by means of surgical intervention. Much research has been done in this respect during recent years and the results in many cases have been satisfactory.

When the cause is unknown, and where surgery is of no value, drug therapy is of assistance in controlling the seizures. Drug therapy varies. Barbiturates in small doses, antispasmodic drugs, such as dilantin and tridione, are given to control or reduce the number of seizures. Diet therapy is of value in some cases. The ketogenic diet is used. It is rich in fatty foods and poor in proteins and carbohydrates; thus in the metabolism of the body there is a production of ketones which affect the general physiology in such a way that the seizures are controlled. The components of this diet are not easy to take and in some quarters it is regarded as having little therapeutic value.

A definite routine type of life is helpful in reducing irritating and exciting situations and thus limiting the number of seizures. Occupations should be chosen so that the person is not endangered if a seizure should occur. For instance, work in a kitchen near a hot stove or at a height should be avoided. Bathing should be supervised—tub rather than shower.

Care During a Seizure

The clothing should be loosened around the neck to facilitate respiration when the seizures occur. To prevent the patient biting his tongue, a roll of soft material should be inserted between the teeth, but *under no circumstances* should a metal or hard object be placed between the teeth nor the jaw forced open during the tonic stage because of the possibility of damaging the teeth. He should be permitted to lie where he has fallen unless endangered by some object which may bring further harm during the seizure. It is well to turn the patient's head to allow the saliva to drain from his mouth. Injuries, particularly hemorrhage, should be treated immediately. Following the seizure, remove the patient to a place where he may be more comfortable, preferably in a recumbent position. He should be under close observation until he has regained full consciousness and is free from any confusion.

Mental Hygiene

Prejudice is roused in the public mind toward those who suffer from epilepsy. This results in a serious handicap being placed upon an epileptic person. Since the prejudice is a result of ignorance, every attempt should be made to enlighten everyone about epilepsy. School teachers should be encouraged to assist such children. Parents in particular should be informed as to the correct method of managing the epileptic child.

References

1. Lennox. Science and Seizures.
2. Noyes and Haydon. Textbook of Psychiatric Nursing.
3. Penfield and Erickson. Epilepsy and Cerebral Localization.

In Memoriam

Agnes Gertrude Barnaby, who graduated from the Victoria General Hospital, Halifax, and practised in that city for over thirty years, died on August 10, 1948, after a short illness.

Edna Elizabeth Fraser, a graduate of the Toronto General Hospital, died on August 26, 1948, after a serious illness. Miss Fraser saw service in World War I, going overseas in August, 1915, with the First Canadian Hospital Unit of the Fourth Division. Her work took her to France, Malta, and Greece. On her discharge from the services, she became a public health nurse in Toronto and until recently was supervisor of the communicable disease division of the health department in that city. She is sincerely mourned by all who knew her.

Margaret Krotchke, who graduated from St. Paul's Hospital, Vancouver, in 1919, died suddenly on August 17, 1948. Following her graduation, Miss Krotchke worked on the staff at St. Paul's and specialled in Vancouver until 1928 when she joined the staff of St. Luke's Hospital in Powell River, B.C. During these twenty years she had served faithfully and well. As surgery nurse she was popular with her co-workers.

Jessie M. McRae, a Canadian who received her training at Blodgett Memorial Hospital, Grand Rapids, Mich., and who served overseas in World War I with the American Expeditionary Force, died in London, Ont., on August 29, 1948. Miss McRae returned to London to reside at the time of her retirement fourteen years ago.

Margaret Evelyn (Harkness) Ruggles died suddenly on August 28, 1948, at her home in Toronto. Mrs. Ruggles was a graduate of the Grace and Riverdale Isolation Hospitals, Toronto.

Occupational Cancer

Definite proof of carcinogenic properties have thus far been obtained from arsenic, tar, pitch, soot, crude mineral oil, crude paraffin oil, anthracene oil, shale oil, some fuel and lubricating oils, creosote, benzene, aromatic amines, ultraviolet rays, roentgen rays, and rays from radio-active substances. Cancers of the lung have also been noted among chromate, nickel, and asbestos workers. Practically every organ in the body may be the site of occupational cancer, but most common are the skin, the bronchi and lungs, the bladder, the blood, the oro-nasal region, and the bones.

— *California's Health*

PRIVATE DUTY NURSING

Contributed by the Committee on Private Duty Nursing of the Canadian Nurses' Association

Anthrax

MURIEL A. WARD

A RARE and exceedingly contagious disease in this part of the world is anthrax. In May, 1946, we observed the tragedies resulting from a septicemia due to the *Bacillus anthracis*.

ETIOLOGY

Anthrax is a specific, acute infectious disease transmitted to man by direct contagion through the skin and mucous membrane. Geographically and zoologically the disease is the most widespread of all infectious disorders. It is much more prevalent in Europe and Asia than in America. In this country the disease is rare. It has never prevailed on the ranches in the west but cases were not infrequent in Montreal at the end of the last century.

The causative organism of anthrax is the *Bacillus anthracis*, which is a rather large (it has a length of from two to ten times the diameter of a red blood corpuscle) gram positive, non-motile bacillus. It grows readily in heaped-up bunches of filaments which interlace and produce a dense network on solid media. It forms spores which are extremely resistant to heat and ordinary disinfectants. It is the only spore-forming aerobic pathogenic bacterium although spores are not formed when oxygen is absent. They persist in the soil for lengthy periods and are distributed in pastures and other areas by the excreta of infected animals or from their dead bodies even when buried.

The soil as an agent of infection was one of the subjects of several investigations made by Pasteur. He proved the presence of these spores in the soil, even three or more years after burial of infected dead animals, which might be dangerous to animals feeding there. This was explained when he demonstrated anthrax spores in earthworm deposits, collected on the surface of the burial ground occupied by infected animals.

After many experiments, Pasteur developed an immunizing agent which consisted of broth cultures of attenuated strains of the bacillus. To prove the effectiveness of this anthrax vaccine, Pasteur in 1881 vaccinated twenty-five sheep with five drops of this preparation. Twelve days later they each received an injection of stronger anthrax organisms. Two weeks later, twenty-five control sheep and the twenty-five vaccinated sheep were each inoculated with a triple dose of anthrax organisms. Within forty-eight hours, all the vaccinated sheep were in perfect health, but twenty-two of the unvaccinated sheep were dead, two others breathing their last, and the twenty-fifth died that night.

Fatigue, bodily or mental, delays

Miss Ward is a private duty nurse in Hamilton, Ont.

and lessens the responses the body needs to make in order to overcome invading organisms. Undue exposure (chilling) has the same injurious effect as shown by Pasteur's classic experiment in which he proved that anthrax, to which chickens are immune, could be induced if an inoculated chicken was also subjected to chilling.

Signs and Symptoms

Anthrax may manifest itself as "wool sorters' disease." Open abrasions on hands, arms, and face can easily become infected by spores from an anthrax-infected sheep.

If the bacteria are ingested, there are systemic symptoms and, in addition, the whole gastro-intestinal tract, from the nose and nasopharynx to the rectum, is intensely congested and hemorrhages occur from the mucous membranes. Intense bloody diarrhea and hematemesis are common.

The respiratory form of the disease, when there is laryngeal, tracheal, bronchial, and pulmonary infection, is intense congestion and rapid systemic dissemination with cerebral symptoms, collapse, and death.

The incubation period is twelve hours to two days. General symptoms are moderate pyrexia, headache, nausea, and general muscular pain. The pulse is weak and rapid with great prostration and collapse.

Case History

Born in Poland in 1893, Mrs. M, a housewife, was the mother of six children, the youngest being seventeen years of age. Her general health was fair. The condition of her teeth was poor, the lower ones being very carious with inflammation along the gum margin which on pressure produced a purulent exudate. At times she suffered from seborrhea dermatitis with sicca of the left upper anterior chest. Arteriosclerotic heart disease was shown by a slight arteriosclerosis and a blowing systolic murmur over the aortic, tricuspid, and mitral areas with a blood pressure of 205/115. In April, 1937, she was hospitalized for chronic appendicitis and chronic exocervicitis from which she had a normal recovery following surgery — appendectomy and biopsy of cervix. Again in August, 1943, she had a normal post-operative course following a hemorrhoidectomy and removal of a tendon cyst of the left foot.

A resident of an industrial centre in Canada for thirty-one years, Mrs. M was admitted to hospital May 11, 1946, at 1:00 p.m., complaining of a very sore throat and unable to speak, with temperature 102°, pulse 66, respirations 24.

A high Fowler's position did little to relieve her dyspnea and by evening her respirations were stertorous. She had difficulty in swallowing fluids.

Throat cultures: The reports showed:

1. From tonsil bed and throat: microscopic — many epithelial cells, gram positive diplococci (pneumococci), gram negative bacilli; culture — *Bacillus anthracis*, *Hemophilus influenzae*, *Staphylococcus aureus* (hemolytic).

2. Swab from nasopharynx: direct smear— many epithelial cells, gram negative bacilli, gram positive diplococci, yeast; culture — *Bacillus aerogens*, *Streptococcus hemolyticus*, *Bacillus anthracis*.

Progress of the disease: The second day in hospital, nausea added to her discomfort and difficulty in swallowing fluids. About 10:00 p.m. she became quite restless and confused, temperature 102°, pulse 104, respirations 28, with slight variation throughout the twenty-four hours.

The third day found Mrs. M very irrational, producing decided hazards in the administration of intravenous therapy. Temperature 103.2°, pulse 130, respirations 34 were recorded on the morning of the third day. A tracheotomy was performed and a No. 5 tube inserted; the wound was packed with sulfathiazole crystals at 1:30 p.m. The anesthetic used was avertin per rectum and cyclopropane. During the night she commenced to expectorate sanguinous mucus. Following the surgical procedure, the patient did not regain consciousness.

On the following day oxygen was administered by nasal catheter; her breathing became very labored. She was incontinent, had diaphoresis, and became very pale. Temperature, pulse, and respirations increased to 105.4°, 166, 48.

The fifth hospitalized day dawned and Mrs. M's respirations were very shallow — 30. She became cyanosed at 6:00 a.m. and her pulse was imperceptible. Respirations ceased 8:25 a.m., May 15, 1946.

Medication: A sedative was ordered for

restlessness — heroin gr. 1/12, q.6.h. p.r.n. This was necessary during the first three days at approximately ten-hour intervals. Following the tracheotomy the patient was unconscious and required no sedation.

Penicillin was ordered on admission, for its bacteriostatic action, in doses of 30,000 units q.3.h. intramuscularly, but after six hours the dose was increased to 40,000 units q.3.h. intravenously for the succeeding twenty-four hours. This was increased again following the surgery to 50,000 units q.3.h. intravenously.

Sodium sulfadiazine 1 in 100 cc. of normal saline q.8.h. was rted post-operatively in addition to the 5% glucose in saline which had been the continuous intravenous since noon on the second day, when nausea complicated the difficulty in swallowing. This continuous intravenous was absorbed at the rate of 3,000 cc. in twenty-four hours.

On the fourth day the laboratory culture reports of *Bacillus anthracis* were available and immediately anthrax anti-serum was used. This is tested first by means of intracutaneous doses of .1 cc.,.2 cc., .5 cc. at half-hourly intervals; 20 cc. intravenously was administered and 50 cc. in 500 cc. of normal saline was given by intravenous infusion. At 2:30 a.m. on the fifth day, 100 cc. of anthrax anti-serum was given intravenously.

Mrs. M's restlessness and mental confusion complicated the intravenous therapy, by causing the fluid to run interstitially frequently at which times the medication was continued by restarting the infusion in different veins.

Nursing care: Mrs. M was suffering from dyspnea both before and after the tracheotomy. Therefore it was necessary to do all nursing procedures with the patient in a medium high Fowler's position. To facilitate the making of the foundation of the bed two nurses were required. One nurse carried out the procedure while the second supported the patient. With this assistance the patient was kept in an orthopneic position while the head of the bed was lowered to permit tightening of the lower bedding.

Since Mrs. M received nothing by mouth extra precautions were required to keep her mouth clean. A mouthwash of lemon juice and glycerin proved most satisfactory. Swabs soaked in this solution were used to keep the gums and teeth massaged and free from sordes. Due to the elevation of her temperature this was necessary very frequently — q.2.h. at least. Albolene was wiped on her lips every half-hour to prevent them from cracking.

When unconscious the patient became incontinent and special care was necessary to prevent her back and hips from developing pressure sores. A thorough washing with hot water and soap, careful drying, and an alcohol massage preceded the application of zinc oxide powder. This powder has a drying effect on the skin when surrounding contacts become damp. This part of the care was repeated as often as necessary. In addition Mrs. M sat on an inflated air-cushion to aid in relieving the pressure. Pillows, protected by rubber covers, were placed under her knees and against her feet to keep the muscles in a relaxed position and relieve pressure from the bedding.

When the nasal catheter for oxygen was in place, albolene was used around the nostril and rubber to prevent excessive irritation. Nose drops of albolene were found to be very soothing to the mucous membrane.

Following the tracheotomy the customary procedure of cleaning the inner tube after removing it was carried out with sterile equipment. This was done when suction failed to clear a passage sufficiently for breathing.

Isolation technique: The *Bacillus anthracis* is an extremely infectious organism. All procedures, therefore, were carried out using the strictest of isolation techniques. A mask and gown were worn by the nurse all the time she was in Mrs. M's room. The nurse's hands were scrubbed with plenty of soap and hot water before and after anything was done for the patient. Shortly after her admission, private duty nurses were available so Mrs. M had constant care and observation.

No equipment was allowed to leave the room and all linen was collected in separate bags. At the end of the case everything — linen, blankets, equipment, rubbers from the bed, pillows and the mattress — was destroyed by burning in the incinerator.

The terminal disinfection of the room was most thorough. Furniture, walls, and floor were scrubbed with formaldehyde solution and soap, then allowed to air for twenty-four hours and scrubbed again. This was completed by re-painting the furniture, walls, and ceiling.

One of Mrs. M's sons was admitted the day following his mother's death with a throat culture positive *Bacillus anthracis*. Ten days after admission, having had large amounts of anthrax anti-serum, his throat culture was negative. He recovered and was discharged.

To protect the health of the nurses on duty on the ward, a close check was ordered. All nurses were required to have their temperatures taken and recorded when reporting on duty. The physician in charge of the nurses' health service inspected the throat of each nurse once a day. At the end of the case each nurse had a throat swab sent to the laboratory for microscopic examination and culture. The reports of all were negative.

REFERENCES

1. Broadhurst and Given. Bacteriology Applied to Nursing.
2. Carter. Microbiology and Pathology for Nurses.
3. Charts and records of Mrs. M.
4. Frobisher. Fundamentals of Bacteriology.
5. Meakins and Osler. Practice of Medicine.

In the Good Old Days

(The Canadian Nurse, November, 1908)

At the second annual meeting of the Canadian Society of Superintendents of Training Schools for Nurses held in October, 1908, it was decided "to form a Provisional Committee and thus organize the National Association." The name given to this committee was "The Provisional Committee of the Canadian National Association of Trained Nurses." The objectives of the new association were:

"1. To promote mutual understanding and unity between Associations of Trained Nurses in the Dominion of Canada.

"2. Through affiliation with the International Council of Nurses, to acquire knowledge of nursing conditions in every country; to encourage a spirit of sympathy with nurses of other nations, and to afford facilities for national hospitality.

"3. To promote the usefulness and honor of the nursing profession."

The officers of the Provisional Committee were to be a president and a secretary-treasurer, elected for a period of from three to five years. It was only natural and right that the honor of being the first president should go to Mary Agnes Snively who had been the most active worker for the formation of the new association. She was ably supported by the loyal assistance of Flora Madeline Shaw as secretary-treasurer.

In addition to the Superintendents' Society, the original national association was composed of the following: Graduate Nurses' Associations of Ontario, Montreal, Hamilton, Ottawa, Manitoba, Vancouver, Calgary, Edmonton; and the alumnae associations of the following hospitals — Toronto General; St. Michael's, Toronto; Kingston General; Sick Children's, Toronto; Western, Toronto; Riverdale, Toronto; General and Marine, St. Catharines; Montreal General; General and Marine, Collingwood, Ont.

"Nurses have largely controlled every advance made in their profession, and it is by their efforts alone preliminary instruction has passed the experimental stage to a definite plan in many of our hospitals . . . Questions arise now, not as to the benefits to be derived from the system, but rather as to the advisability of continuing a scheme where probationers render no service to the hospital but, on the contrary, are an item of expense . . . The preliminary course is only a stepping-stone to the central school system. In many sections technical schools have proved of great value, and it is not too much to expect that our public schools may yet offer an elective course to this as to other professions."

"A small percentage of the public are under the impression that when they enter the pay ward of a hospital the fee for lodging and maintenance covers the charge for treatment. They apparently forget that the physicians and surgeons give services free to those who cannot pay — so those who can pay must pay."

"Miss Isabel Stewart (W.G.H.) is taking the hospital economics course at Columbia University, New York. We wish more of us could follow her example."

"Do not fail to write today for Eaton's Christmas Catalogue. Mention *The Canadian Nurse*."

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Importance of Orientation Programs for New Employees

BEATRICE M. HUNTER

THE DEFINITION of the word "orientation" given by George E. Meyers in his book "Principles and Techniques of Vocational Guidance" gives us an excellent general idea of the meaning of this term. Mr. Meyers says that orientation is "the process of assisting the individual to choose an occupation; prepare for it; enter upon and progress in it." This description can very well serve as a guide and be adapted to suit the requirements for a hospital orientation program.

Such a program is an invaluable aid to both nursing and administrative personnel. It promotes teamwork within departments, understanding and co-ordination between different departments.

AIMS AND ADVANTAGES

The aim of such a program is, of course, a smooth running organization, resulting from peak performances on the part of its individual members. This ensures the greatest possible benefit to the patient, by achieving and maintaining the quality and quantity of service for which our hospitals are noted.

Miss Hunter is matron of the Veterans' Hospital in Quebec City.

The advantages of a good orientation program may be considered from two major angles, that is: from the point of view of the employee and from that of the hospital. As "personnel" is the most important component of any organization, and as morale of the personnel is the greatest single contributing factor in good job performance, this should be developed in the new employee by giving her a favorable first impression, by providing encouragement and security in her new environment, and by giving her an insight into the importance of her work. Thus, instead of being permitted to learn her duties by the trial and error method, and instead of being allowed to feel confused and ineffectual in strange surroundings, the new employee is helped and guided. The advantages derived by the hospital administration from such a program are manifold:

It benefits by a well-selected personnel.

New employees are better equipped to become contributing and efficient factors in the unit.

Maximum results are obtained by making the best use of potential skills of employees.

Good personnel relations are built up.

The hospital is enabled to fulfil its obligation of providing the finest possible service to its patients.

WHO IS RESPONSIBLE?

The matron: Although the responsibility for the successful application of a good induction program is vested on many individuals, the matron is in a key position in the initiation of such a program. The groundwork for future good relations and orientation may be laid in most instances by the matron on the occasion of the first contact with a prospective employee. This may be when an individual presents herself at her office soliciting information with a view to submitting an application for some position available on the staff. Or again, this first contact may occur if she is acting as technical adviser on a Review Board, D.V.A., in her own district. In either case, the matron should deal with the person concerned in a pleasant and re-assuring manner; give her all the information pertinent to the position in which she is interested; advise her concerning rates of pay, holidays, sick leave, pensions, etc.

Now, while such an interview is helpful to the applicant, it also offers an invaluable opportunity for the matron, first of all, to obtain information concerning the background, experience, and preferences of the applicant; secondly, it enables her, if she is a discerning person, to form a fairly accurate opinion of the character and personality of the person she is interviewing. Thus she may decide whether the prospect is a desirable one, or whether she is the wrong type and should be deftly discouraged from submitting an application.

When the newly appointed employee reports at the hospital on her first day she should be received by the matron in a friendly manner. This puts her at ease, makes her feel that she is personally welcome and necessary to the functioning of the establishment, and not just an extra pair of hands and feet. By this personal touch you will unfailingly have won her loyalty from the first. This is important.

If this nurse has not been engaged for a specified position, you will, after having taken into consideration her past experience and her preferences, explain to her the duties to which she has been assigned, the general rules and policies of the hospital, and you will subtly make her aware of what is expected of *her* in the way of high standards in personal habits, professional skill and ethics. Let her know that you represent a fair and just administration; and that she may approach you at any time for advice or guidance.

Following this she may be introduced to the superintendent of the hospital, the personnel officer, and the head of the department where she is to work. If the new employee herself is to be the supervisor of a department she should be introduced as such to her future subordinates, (who have previously been advised of her appointment), and to the heads of all other departments in order that each may be made aware at once of the status of the other. This makes for efficient co-ordination between departments.

Immediate supervisors: The department supervisor then takes over. These are the real personnel managers, as they are persons on whom the immediate responsibility rests for carrying out the training-on-the-job planned by the administrative heads. I have not found it necessary to lay down any set rules to be followed by my charge nurses and supervisors in inducting new employees. I have assured myself that they are conscious of their great responsibility in this matter; and I have checked on the methods followed by each one in their respective departments and I find that they all obtain gratifying results. A composite picture of their efforts is dominated by a spirit of friendliness and patience and an attitude of helpful interest.

The new employee is introduced to all the fellow-workers, as well as to the attending doctors. Now a person delegated by the charge nurse shows her around the hospital, giving her factually accurate information concerning all its departments. She is then shown every part of her own department and given clear, concise directions regarding its activities and

functions. She is assured that she is not expected to absorb and remember all the phases of her work on the first day, but rather is impressed with the fact that it is desirable that she learn thoroughly a small part of it each day. The new employee is not posted to night duty, nor is she left alone in charge of a department until she herself feels assured that she has become familiar enough with all departmental routines and hospital policies to deal competently with any emergency. She is always advised in advance and given reasons for any changes which concern her work.

All other members of the staff, over whom you have no jurisdiction but who necessarily play a vital role in orientation of a new employee, will invariably take their cue from you. The non-medical men will be inclined to be rather businesslike and impersonal in their approach to this subject, but nevertheless they are responsive and helpful and most willing to co-operate with you in any plan that tends to promote the good functioning of the institution as a whole. The regular monthly staff conference conducted by the administrative authorities contributes greatly to the success of the orientation program.

Summary

To summarize and conclude this brief study of the orientation of a new employee, it is an important part of the program because a worker's success depends to such a great extent upon the manner in which she is introduced to her job. Therefore, every effort should be made to give her the information and inspiration which she needs. This should *not* be left to chance.

It has been proven by experienced administrators that the time and effort invested in developing skill and good morale pays good dividends, not only in terms of efficient service, economical operation, and reduced employee turn-over, but in increased personal effectiveness, professional reputation, and good-will.

A to Z

Adactylous: Lacking fingers or toes.
Bathypnea: Deep breathing.
Chappa: A disease of South Africa resembling syphilis or yaws.
Desmopathy: Any disease of the ligaments.
Ectiris: The retinal or external portion of the iris.
Flavedo: Yellowness, as of the skin.
Gelosis: A hard swollen lump.
Hersage: The loosening of the fibres of a diseased nerve trunk.
Immiscible: Incapable of being mixed.
Jactitation: Tossing to and fro in acute sickness.
Kolytic: The temperament marked by calmness and self-control.
Levuride: A dermatitis occurring in certain fungus infections.
Metranemia: Uterine anemia.
Nyxis: Puncture or pricking.
Obcecation: Partial blindness.
Paraglossa: Swelling of the tongue.
Quinoxyl: A proprietary amebicide.
Rupophobia: Unreasonable fear of dirtiness.
Salifiable: Capable of combining with an acid to form a salt.
Teratoma: A tumor containing fetal remains.
Ungual: Of, or pertaining to, the nails.
Vitellus: The yolk of egg.
Waster: An ox or cow affected with tuberculosis.
Xenophonia: Alteration in the quality of a person's voice.
Yxin: A silver glucose salve used to stimulate epithelial growth.
Zymocyte: An organism which causes fermentation.

Attention! Stamp Collectors

If any nurse has used postage stamps to spare, including Canadian, American, and foreign, there is a patient in a sanatorium who would be pleased to receive them. He is *Mr. G. E. Marcil* at *Cooke Sanatorium, Three Rivers, Quebec.*

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Service Généralisé de l'Infirmière dans un Service d'Hygiène Publique

ADÉLARD GROULX, M.D., M.P.H.

LE SERVICE d'infirmières hygiénistes a eu son origine en Amérique, en 1877, quand le Women's Branch of the New York City Mission organisa un service d'infirmières qui étaient envoyées au domicile des malades. La première infirmière-visiteuse fut engagée par l'Ethical Culture Society cette même année. En 1902, les premières infirmières sont engagées au Service de santé de la ville de New-York, dont une dans les écoles et une autre à la division de l'hygiène de l'enfance.

Au sujet de l'infirmière-hygiéniste, le Dr C. E. A. Winslow, de Yale School of Medicine, dit: "In my judgment the visiting nurse is the most important figure in the modern movement for the protection of the public health."

Au Canada, la première école de gardes-malades fut fondée en 1873 à St-Catharines, Ont. Les autres provinces ne tardèrent pas à suivre cet exemple et bientôt il y en eut dans tout le pays.

Le champ d'action de l'infirmière, d'abord limité aux institutions hospitalières, ne tarda pas à grandir parce que la population réclama ses services à domicile et c'est alors que furent fondées ces associations si dignes d'admiration, dont les membres soignent les malades partout, dans toutes les familles, pauvres comme riches.

Le docteur Groulx est directeur du service de santé, Montréal.

L'infirmière-hygiéniste est celle dont le rôle et les fonctions consistent dans l'éducation de la famille et des individus concernant les préceptes de l'hygiène et la conservation de la santé, ou qui tout en accomplissant un travail spécial a pour mission additionnelle la vulgarisation des principes sanitaires. Il y a deux catégories d'infirmières-hygiénistes:

1. Celle qui est attachée à un *service officiel* d'infirmières-hygiénistes.

2. Celle qui appartient à un *service bénévole* d'infirmières-visiteuses, donnant les soins aux malades à domicile, comme la Société des infirmières-visiteuses, l'infirmière-visiteuse de la Metropolitan Life Insurance Co., le Victorian Order of Nurses, etc.

Ce n'est pas mon rôle, ici, de vous parler de cette deuxième catégorie de l'infirmière-visiteuse. Le rôle que l'on m'a confié consiste à vous entretenir des fonctions de l'infirmière-hygiéniste attachée à un organisme officiel qui peut être le Ministère de la santé et ses unités sanitaires et les services de santé municipaux.

D'autre part, cette communication n'a pas la prétention d'être parfaite et complète, rédigée comme elle l'a été, à travers les multiples difficultés et problèmes administratifs de tous les jours; elle ne sera que le reflet de certaines considérations et expériences personnelles sur la question du nursing.

Son objet, en plus, n'est pas de vous décrire tous les éléments qui concernent l'infirmière-hygiéniste —

qualifications, responsabilités, activités — mais de vous faire voir l'importance d'un aspect particulier actuel de ses fonctions: *Le service généralisé de l'infirmière dans le champ d'action bien déterminé de l'hygiène publique.*

Il est bon, cependant, de rappeler brièvement quelles sont les qualifications requises d'une infirmière-hygiéniste:

1. Etre diplômée d'une école de gardes-malades reconnue.

2. Etre enregistrée dans l'Association provinciale des gardes-malades.

3. Etre diplômée en hygiène publique d'une école ou université reconnue à la suite d'une année post-scolaire d'études et d'entraînement spécialisé.

4. Enfin, avoir acquis une certaine expérience.

Le service du public health nursing dans nos organisations officielles et publiques et dans certaines organisations bénévoles a pris beaucoup d'importance. Il s'est accru de façon imposante à mesure que le budget des services de santé a augmenté. On me rapporte que le Ministère provincial de la santé dans les services spécialisés et dans les unités sanitaires compte 391 infirmières. Le Service de santé de la ville de Montréal compte avec le budget actuel (1948-49) 185 infirmières. Notre ambition est de porter graduellement ce nombre à 200. Je ne compte pas ici le nombre des infirmières-hygiénistes qui, dans notre ville, sont attachées à des organisations bénévoles d'hygiène, comme la Ligue antituberculeuse, l'Institut Bruchési, le Royal Edward Institute, les Gouttes de lait paroissiales, la Child Welfare Association, le Service social de la division provinciale des maladies vénériennes, et d'autres. Il serait intéressant d'en faire le bilan.

La valeur de ce service devient donc apparente immédiatement et les services rendus font voir de plus en plus les résultats efficaces obtenus dans certains domaines.

Fonctions de l'Infirmière-hygiéniste

La fonction primordiale et fondamentale de l'infirmière-hygiéniste est l'enseignement de l'hygiène. Elle est un besoin des temps actuels, besoin réalisé avec l'extension de l'éducation et de l'enseignement de l'hygiène dans la famille, base fondamentale de la société. Sa fonction majeure consiste à enseigner et à instruire; son rôle est celui d'une institutrice; même si elle appartient à une organisation dont la fonction consiste dans les soins aux malades à domicile.

La famille est l'unité essentielle où peut se faire l'enseignement pratique de l'hygiène; c'est là que l'infirmière accomplira avec le plus d'efficacité sa mission d'éducatrice et d'aviseur par son contact avec la mère et les enfants, et, j'ajouterai, même avec la père, au cours de réunions et conférences. L'éducation familiale est, en effet, la plus pratique et la plus efficace.

C'est son devoir, écrit Smillie, d'aider chaque famille dans le domaine de sa juridiction pour prévenir la maladie et pour promouvoir l'hygiène chez tous ses membres. Une attention spéciale doit être donnée aux mères et aux jeunes enfants.

Dans l'accomplissement de ses fonctions, elle aide le médecin à réajuster les conditions sociales.

Pour atteindre son but, comme je l'ai déjà dit dans une conférence antérieure, l'infirmière doit être instruite, convaincue de sa mission, intelligente, dévouée et avoir beaucoup de tact; elle doit aimer les enfants et posséder l'autorité nécessaire pour imposer ses conseils aux mères.

En second lieu, l'infirmière-hygiéniste est celle qui, par son travail, entre dans plus de foyers que tout autre travailleur social, et si son travail est bien dirigé elle peut être un facteur très important dans le dépistage et le traitement précoce de la maladie. C'est d'ailleurs une de ses fonctions et un de ses devoirs d'assurer et d'aider à l'obtention d'un traitement immédiat et adéquat. C'est enfin une autre fonction importante de l'infirmière qui, par son contact avec les familles, a la confiance de ses gens, peut aussi leur démontrer la nécessité et la valeur de certains traitements et leur technique et leur expliquer l'importance d'un traitement continu et prolongé dans le cas

de certaines maladies, telles la tuberculose ou la syphilis, etc. Ses qualités féminines et personnelles lui viennent en aide dans ce rôle.

Pour cela, elle doit posséder quatre qualités que je crois essentielles pour les avoir citées déjà: la compétence, la loyauté, le désir intense de rendre service et avoir de la personnalité et de l'éducation. Quand elles sont averties et dévouées, les infirmières sont des auxiliaires précieuses dont le rôle, je le répète et j'insiste, se manifeste surtout dans les familles.

Activités

Je n'ai pas l'intention de décrire ici chacune de ses activités dans le domaine de la santé publique. Je dois vous donner cependant un sommaire de son champ d'action qui est assez vaste, vous pouvez le constater, pour se rendre compte des activités de l'infirmière-hygiéniste:

1. *Sur l'hygiène maternelle* par l'éducation prénatale, l'aide aux futures mères à se préparer pour la naissance du bébé, dans certains services organisés assistent à l'accouchement; font suite aux instructions des médecins, et aident dans les cliniques prénatales.

2. *L'hygiène infantile et préscolaire*, par les visites post-natales, des bébés et des enfants d'âge préscolaire, instruction des mères concernant les soins et l'alimentation de l'enfant, l'aide dans les consultations de nourrisson et préscolaire; l'obtention de certains défauts corrigibles avant l'entrée à l'école, telles: dents cariées, nutrition, végétations adénoides, et amygdales hypertrophiées.

3. *L'hygiène scolaire* où l'infirmière joue un rôle important par son assistance aux médecins scolaires dont elle est l'auxiliaire; l'inspection médicale des écoles, le contrôle de la contagion et des maladies parasitaires et son travail d'éducation dans les familles pour persuader les parents dans la correction des défauts physiques et son aide active chez les pauvres à obtenir les traitements appropriés.

4. *Le contrôle des maladies contagieuses* par l'enseignement à domicile des principes de l'épidémiologie, la désinfection concurrente et terminale à domicile et des sources de contamination. Son rôle est aussi important et efficace dans ses visites et aux cliniques dans la lutte contre la tuberculose et les maladies vénériennes.

5. *Sur l'alimentation rationnelle et la nutrition* par l'enseignement des principes qui la dirigent — l'achat, le choix et la cuisson des aliments, le budget familial pour un régime alimentaire bien balancé.

6. *L'hygiène dentaire* pour assurer la bonne dentition des enfants et la préservation de leur denture par l'enseignement des mesures de prophylaxie et des soins nécessaires, y compris la visite bi-annuelle au dentiste.

7. *En hygiène mentale*, dont l'importance grandit dans son travail d'enquête familiale et de visite, et en *hygiène industrielle* où elle a une fonction et un champ d'action plus spécialisé par son travail de prévention et d'éducation auprès des employés à qui elle est appelée à donner des soins urgents.

Certaines de ces fonctions de l'infirmière-hygiéniste ont fait l'objet dans le passé de services spécialisés. Sauf l'hygiène industrielle, toutes ces activités que nous venons de résumer et qui composent son programme d'action, au cours de son travail dans la famille, doivent faire partie du service généralisé de l'infirmière-hygiéniste, orientation actuellement donnée à l'organisation du nursing en hygiène publique.

Je suis d'opinion que dans le cas de la tuberculose et des maladies vénériennes, l'enseignement actuel est définitivement en faveur du service généralisé. Le service généralisé est:

Plus économique — (a) *Economie de temps:* L'infirmière en faisant une visite de contrôle de tuberculose peut faire en même temps une visite de contrôle de maladie vénérienne dans le voisinage. On ne verra pas, par exemple, deux ou trois infirmières d'un même bureau de santé à peu près en même temps dans une même maison à appartements: l'une faisant un contrôle en tuberculose, l'autre un contrôle de maladie vénérienne, et la troisième un contrôle de maladie contagieuse. (b) *Economie de personnel*: On aura besoin de moins d'infirmières (c) *Economie d'argent:* Découlant de l'économie de temps et de l'économie de personnel.

2. *Plus efficace au point de vue hygiène publique:* (a) Au cours d'un travail spécialisé l'infirmière généralisée saisira mieux dans une famille ou chez un individu les à-côtés d'hygiène publique qui peuvent s'offrir. (b) Par ailleurs, au cours de son travail de routine l'infirmière généralisée peut noter et rapporter des faits qui aideront le contrôle des maladies conta-

gieuses, de la tuberculose, et des maladies vénériennes.

3. *Aussi apte à donner de bons résultats:* Si l'infirmière généralisée est bien entraînée, bien guidée, elle fournira en définitive un travail aussi efficace pour fins de contrôle de la tuberculose et des maladies vénériennes qu'une infirmière spécialisée.

Le service généralisé de l'infirmière en hygiène publique a pour but de lui permettre de faire l'éducation des familles concernant les principes de l'hygiène qui concernent tous les problèmes dont je viens de parler brièvement. De plus, il est nécessité par le fait que l'on considère la famille comme le centre même où doit se faire cet enseignement de façon pratique et efficace.

Il a aussi pour but de prévenir la duplication des visites par l'emploi d'infirmières à chacune des spécialités dont il a été question plus haut. La même infirmière, bien préparée et bien dirigée, est le meilleur trait d'union entre le service de santé et la famille sur tous les problèmes et besoins qui la préoccupent. Pour cela, elle doit posséder les quatre qualités mentionnées plus haut, et pouvoir en faire bénéficier ceux qu'elle visite et avec qui elle vient en contact.

Par le service généralisé l'infirmière-hygiéniste doit aborder tous les problèmes qui intéressent tous les membres de la famille. Selon l'expression de Smillie, elle constitute un Family Health Service.

Pour organiser adéquatement un service généralisé d'infirmières-hygiénistes, il faut une infirmière par 5,000 de population pour le travail en hygiène publique; dans le second cas, si le plan comprend le bedside nursing il faudrait une infirmière par 2,000 de population.

D'après la National Organization for Public Health Nursing les responsabilités générales de l'infirmière-hygiéniste dans un service généralisé sont:

1. D'aider à obtenir un diagnostic médical et un traitement précoce.

2. De procurer les soins du nursing au patient.

3. D'enseigner par des démonstrations et de surveiller les soins donnés par les parents ou par son entourage.

4. D'aider la famille à observer les méthodes médicales, sanitaires, et sociales pour la prévention des maladies et le maintien de la santé.

5. D'aider à faire le réajustement des conditions sociales qui affectent la santé.

6. D'influencer la société à améliorer la santé publique, par l'établissement d'un programme éducationnel.

Toutes les fonctions des infirmières-hygiénistes prises dans leur ensemble forment un programme bien rédigé de public health nursing. Tous les éléments d'un semblable programme s'enchaînent et doivent être en relation étroite avec les autres phases du public health nursing. On peut difficilement séparer une activité des autres qui peuvent être requises dans une même famille. D'où l'importance qu'il y a au point de vue efficacité et économie qu'une même infirmière, dans un territoire limité, accomplisse toutes les fonctions.

Il est reconnu que la plupart des activités mentionnées plus haut sont communes à tout le nursing.

A ces activités s'ajoutent celles concernant l'hygiène de l'adulte, qui lui permettent d'encourager l'examen médical périodique et d'enseigner les principes de l'hygiène personnelle en vue de prévenir ou de retarder les maladies spécifiques à cet âge, et aider à obtenir un diagnostic et un traitement précoces.

Dans le domaine de la salubrité, l'infirmière-hygiéniste peut enseigner l'importance de corriger certaines conditions d'insalubrité et les mesures de protection qui se rapportent à leur correction, observer les conditions de ventilation et de protection contre les moustiques par les moustiquaires, etc., j'ajouterai qu'elle peut enquêter sur les sources d'approvisionnement d'eau potable, de lait, et les moyens de manipulation des aliments et sur les dispositions des égouts et des rebuts.

L'hygiène mentale: Quant à l'hygiène mentale, il semble bien qu'elle fasse partie intégrale du public health nursing. Selon Miss D. J. Roberts:

It is a vital part of the nurse's equipment

and it weaves itself into the pattern of her daily activities with infinite variation. In every aspect of her work it enables her to render better service, more helpful to her patient, more satisfying to herself.

In these days when the focus of the public health nurse's attention is the family, the mental hygiene emphasis on human beings in their inter-relationships takes on new meaning.

Organisation

Il est nécessaire d'avoir une administration efficace du nursing dont les activités doivent être co-ordonnées pour répondre aux besoins essentiels. *Le besoin d'une direction administrative et scientifique est essentiel et primordial.* La directrice ou l'infirmière-chef, quelle que soit la dénomination qu'on lui donne dans un grand service, doit posséder les qualités primordiales d'un chef.

Il doit exister un Bureau du Nursing qui peut être une division du service de santé comme cela existe dans bien des endroits, ou une section d'une division importante d'un service de santé, soit la division de l'hygiène de l'enfance qui couvre déjà une grande partie des activités du nursing, ou mieux encore des districts sanitaires qui, par leur organisation et leur fonctionnement, viennent faciliter le travail généralisé de l'infirmière-hygiéniste.

Il faut de toute nécessité un personnel état-major du nursing bien qualifié composé d'une infirmière-en-chef, directrice ou surintendante, peu importe la dénomination, d'assistantes et de chefs de groupe ou surveillantes compétentes.

Je n'ai pas l'intention malgré l'importance du sujet d'entrer ici plus avant dans cet ordre d'idées qui peut faire l'objet d'une étude intéressante et plus complète. Je prends pour acquit la nécessité de la chose et d'une bonne direction.

Indépendamment de ceci, de l'existence d'un bureau du nursing avec personnel dirigeant qualifié, le médecin-hygiéniste a son rôle à jouer; il a son importance et il doit prendre ses responsabilités. C'est de lui que viendront les instructions spécifiques sur le travail à faire au cours des visites à domicile ou à l'école par l'infirmière, soit pour le contrôle de la contagion, la recherche des contacts, les corrections à obtenir, etc. Il devra cependant, tout en s'y intéressant, laisser aux supervisors le soin de contrôle et de diriger les choses du nursing: les méthodes de travail, d'approche, d'éducation, etc. Pour obtenir de l'efficacité, le médecin-hygiéniste et l'infirmière chef de groupe doivent collaborer ensemble, travailler conjointement la main dans la main. Ils sont tous deux responsables de la qualité du travail et de son rendement.

Conclusions

Le succès du service généralisé en hygiène publique peut dépendre de trois facteurs bien importants:

1. Avoir un plan d'entraînement élaboré et suivi pour fournir à chaque infirmière-hygiéniste les connaissances essentielles qui lui permettent d'accomplir efficacement son travail — même spécialisé.

2. Une surveillance spécialisée dans les domaines spécialisés: maladies contagieuses, tuberculose, maladies vénériennes et même hygiène mentale, par des surveillantes spécialisées, responsables du travail que sont appelées à faire les infirmières-hygiénistes dans un service généralisé, dans leurs spécialités.

3. La surveillance dans un district donné dont le rôle est essentiel et dont l'efficacité sera d'autant plus grande que la surveillante aura le support du médecin-hygiéniste, de sa directrice et de tous ses supérieurs, sans compter la considération et le respect et la confiance des infirmières-hygiénistes qui travaillent sous sa directive immédiate.

Le succès de toute l'organisation dépend de l'esprit qui règne et du travail d'équipe qui s'accomplit.

La personnalité de la surveillante est aussi un facteur de succès. "The essence of supervision is," écrit O. Tead, "in the supervisor herself, her character, her technical knowledge, her tactfulness, her patience, her sensitiveness to the reactions of others, in her constant alertness for a sense of agreeable human relationship."

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Immunization in a Rural District

CAROLINE C. MACDOUGALL

SHORTLY after beginning work in the County of Inverness, Cape Breton Island, an outbreak of diphtheria occurred in Inverness town (population 2,500). Immediately, measures were undertaken by local physicians working closely with the Department of Public Health to treat existing cases; prevent further spread of the disease; and uncover epidemological factors which caused the outbreak. Due to the united efforts of all workers, a large scale epidemic was aborted and the rise in mortality and morbidity rates was kept at a minimum.

Following the outbreak in Inverness town, sporadic cases occurred in the outlying country districts. These cases were in districts in which immunization clinics had not been held for a period of years, due to lack of medical and nursing personnel. It was decided, therefore, that some method would have to be adopted promptly whereby every child would receive the benefits modern science had forged to combat the dreaded diphtheria. Due to road conditions, distances between districts, plus the inability of doctors to leave their offices for long periods of time, it was decided to have the public health nurse in the district arrange the clinics and give the toxoid. Since a generalized program of public health nursing is carried on in the district, many excellent opportunities for teaching the value of immunization were available and, consequently, when clinics were begun we felt the groundwork had been laid.

As soon as roads were easily travelled, work was started. The most remote settlements were first chosen and a program was arranged. Each teacher was informed of the date set for the clinic in her area and the pupils carried home the information to their parents. Announcements concerning clinic schedules were made by the clergy on the Sunday previous to the clinic. The co-operation of teachers and clergy was of inestimable value. Clinics were held at the schools and the aid of the teachers was enlisted in filling out the immunization records. While the teacher filled in the forms, the nurse was able to set up her equipment. Equipment had been autoclaved at one of the local hospitals before starting out, so the first set-up was quite simple. Subsequent sterilization was done with a Sterno stove. Plain diphtheria toxoid, 1 cc., was given to children who had had whooping cough or who were over nine years of age. Combined diphtheria toxoid and pertussis vaccine, 2 cc., were given to children six months to nine years of age if they had no history of pertussis. Three doses were given at intervals of four

Miss MacDougall is a public health nurse with the Cape Breton Island health unit, N.S.

to six weeks. Alcohol was used to cleanse the areas of injections and we had no trouble with infections. The teacher, one of the older pupils, or one of the mothers swabbed the arms. Individual attention was given to each child as he was brought up for his dose and this helped to create a friendly atmosphere and dispel his fears. Parents were told of reactions which might occur and given instructions regarding care. Thus unnecessary worry and prejudice against toxoid were eliminated. The date and place of the next clinic was also made known at this time and the importance of attending the series of clinics stressed.

An average of five clinics was held each day. This may seem a small number but travelling time, setting up clinics, record-keeping, and delays had to be taken into consideration, plus the fact that our generalized nursing program had to be carried on concurrently.

Response to the second series of clinics was good although not 100 per cent. Investigation was made to discover the reason for the absences. Visits to the homes of the absentees proved to be interesting. In one home from which five children missed the clinic it was discovered they lived two miles from school and had no means of transportation. Due to severe varicose veins the mother was unable to walk and the children were too young to send alone. In another home was a case of measles. In another, the child had been removed to the hospital for an appendectomy. In another home the mother was ill and there was no one to send with the children. In these cases the second dose of toxoid was given in the home and the parents urged to make some arrangements for the third clinic. Response to the last clinic was also good. There were only three cases where indifference was the cause of absenteeism from the second or third clinics.

On checking completed records, it was found that 96 per cent of the group had received two doses and 93 per cent the three doses. This was gratifying for we knew that many of the parents had long distances to travel by horse and wagon and the weather was not always clement. The teaching regarding the value of immunization appears, therefore, to have been effective.

℞ *Chuckles* P.R.N.

Sedative pacts relieve muscle spasms in Korea.

A poop tent is frequently ordered in respiratory treatments.

One function of the lymph nodes is to secrete perspiration.

Patient to nurse: "I'm that fond of cats, I've caught Persian anemia."

Do not give your patient medicine if you notice he is unconscious.

The semicircular canals are useful to prevent infection of the middle ear.

Bile is secreted by the kidneys.

Do not use the same instruments, dropper, towel, etc., for more than one baby without boiling or sterilizing it.

A pregnant woman should keep her mind as well as her body spotlessly clean.

An incubator is a wooden furnace.

Culture media is the place where organisms are grown so they can be observed carefully. The organisms are given the best of food and attention, in order to grow healthy specimens, that can be used later for reference.

Old Age Pensions

The number of persons receiving old age pensions in Canada at the end of 1947 was 223,364. The average monthly pension ranged between $29 and $30 in every province except P.E.I. where it was $24.53. In no province was the number of pensioners as high as 3 per cent of the total population. — *The Labour Gazette*

Notes from National Office

A shortage exists in adequately trained nurses, according to a report on *Nursing for the Future* prepared for the National Nursing Council of the United States by Esther Lucile Brown. Far-reaching changes in nursing practice and in nursing education are recommended. The study was financed in part by a grant from the Carnegie Corporation of New York and is published by Russell Sage Foundation, from whose staff Dr. Brown was drawn to direct the survey.

The expectation that the nursing shortage would be relieved at the expiration of wartime demands has not been realized, says the report. In many hospitals, wards and even floors remain closed because there are not enough nurses to permit reopening. Planned expansion of health services has sometimes not been possible because nurses required for such preventive programs had to be assigned to the care of those already sick.

Unless changes are made in the recruitment and education of nurses, the prospect for the future is not encouraging, reports Dr. Brown. The Women's Bureau of the United States Department of Labor recently estimated that 500,000 to 550,000 nurses would be needed by 1960, if only current standards of nursing are maintained. Twice as many will be required if the proposed more adequate care for mental patients and other unmet needs are to be supplied. But the lowest of these estimates, 500,000, is about 200,000 higher than the number of nurses available at the last count, in 1946. To reach merely the 550,000 estimate, graduates from 1951 to 1960 will need to average over 45,000 a year; but in 1947 admissions to the 1,253 state-accredited schools totalled only 38,000, and more than 30 per cent of those enrolled are expected to drop out before graduation.

Nursing has been fighting a losing battle in attracting the needed number of young women, says the report. Where formerly nursing and teaching were almost the only occupations open to the young woman, today a vast variety of occupations and professions beckon to her, often offering better salaries and working conditions. "Many thoughtful persons," says Dr. Brown, "are beginning to wonder why young women in any large numbers would want to enter nursing *as practised*, or schools of nursing *as operated*, today." Salaries in the United States for the average graduate nurse, paying for her own living quarters, averaged between $170 and $175 a month in October, 1946, and her work-week averaged 44 hours. Nurses serve under authoritarian direction in hospitals, caught between the authority exercised by the medical administration on one hand and the hospital administration on the other.

Nursing, with its opportunities for helping others, has a deep intrinsic appeal, but if enough young women are to be attracted to this service it must be supported, believes Dr. Brown, by better salaries, more stable working conditions, and an environment freer from authoritarianism. More men nurses are needed. Nurses who have married and whose children are now grown should be re-trained and returned to useful service. Students and personnel should be recruited, recommends Dr. Brown, "without regard to sex, marital status, economic background, or ethnic, racial and religious origins."

Solution of the immediate emergency, believes Dr. Brown, will re-

quire more careful functional organization of nursing service, with many of the less complex duties carried by the trained practical nurses and other nursing assistants working under supervision. This will release the limited supply of graduate bedside and professional nurses for the care of the critically ill and supervisory duties. But nursing assistants should be limited to functions they can safely perform, and sound legislation should be passed in all states where it does not already exist to set up qualifications for the practical nurse, as has already been done for the R.N.

Conditions in nursing education are regarded as central to the whole problem. "By no conceivable stretch of the imagination," the report charges, "can the education provided in the vast majority of the some 1,250 schools be conceived of as professional education. Many hundreds of hospitals still operate schools to avail themselves of the services of student nurses." Approximately half of these schools have fewer than 100 students. A recent evaluation of 602 smaller schools by the United States Public Health Service indicated that only 4 per cent were excellent or good; 50 per cent were fair; and 46 per cent were poor or very poor. The report recommends:

That nursing make one of its first matters of important business the long overdue official examination of every school.

That the lists of accredited schools be published and distributed, with a statement to the effect that any school not named had failed to meet minimum requirements for accreditation or had refused to permit examination.

That a nationwide educational campaign be conducted for the purpose of rallying broad public support for accredited schools, and for subjecting slow moving state boards and non-accredited schools to strong social pressure.

Editor's Note: "Nursing for the Future" may be obtained from the Russell Sage Foundation, 130 East 22nd St., New York City 10. The price (in U.S.A.) is $2.00.

Notes du Secrétariat de l'A.I.C.

Il existe une pénurie d'infirmières bien qualifiées, voilà la conclusion d'un rapport préparé à la demande du National Nursing Council des Etats-Unis, par Esther Lucile Brown.

Des changements d'une grande portée sont recommandés dans la pratique du nursing aussi bien que dans l'éducation de l'infirmière.

Cette étude est publiée par la Russell Sage Foundation (organisation américaine qui a pour but de faire des recherches pouvant améliorer les conditions sociales). La Carnegie Corporation of New York a défrayé une partie des dépenses occasionnées par cette étude. Le Dr Brown, directrice de l'enquête, fait partie du personnel de la Sage Foundation.

Les espérances entretenues durant la guerre, à savoir: Que la pénurie d'infirmières cesserait dès la fin des hostilités ne se sont pas réalisées, est-il dit dans ce rapport. Dans bien des hôpitaux des salles et même des étages entiers sont fermés parce qu'il n'y a pas encore suffisamment d'infirmières pour en permettre la réouverture.

Il a été aussi impossible de développer les services de santé. Les infirmières qui auraient dû travailler à l'exécution d'un programme de prévention sont retenues auprès des malades.

"Si l'on n'opère pas des changements dans la façon de recruter et d'éduquer les infirmières, l'avenir de la profession n'est pas brillant," dit le Dr Brown. Le Women's Bureau du Ministère du Travail aux Etats-Unis prévoyant que pour 1960 le nombre d'infirmières dont on aurait besoin serait de 500,000 à 550,000 et celà si l'on ne fait que maintenir les cadres actuels du nursing.

Ce chiffre se double si l'on veut améliorer les soins donnés aux malades mentaux et aux autres catégories de malades dans le besoin. L'évaluation la plus basse soit 500,000 est inférieure de 200,000 au nombre d'infirmières disponibles d'après le relevé fait en 1946.

Pour atteindre ce chiffre, la moyenne des diplômées de 1951 à 1960 devrait être de 45,000 annuellement. En 1947 l'admission dans les 1,253 écoles certifiées était de seulement 38,000 élèves et de ce nombre l'on estime que 30 pour cent quitteront l'école avant d'avoir complété leur cours.

La profession d'infirmière s'est battu en vain pour attirer dans ses rangs des jeunes filles dont on a tant besoin, dit le rapport.

Autrefois, les seules carrières ouvertes aux femmes étaient celles d'institutrice et d'infirmière, tandis qu'aujourd'hui une grande variété d'occupations et de professions lui sont offertes et souvent à des conditions de salaire et de travail supérieures.

"Bien des personnes réfléchies," dit le Dr Brown, "commencent à se demander pourquoi un grand nombre de jeunes filles voudraient embrasser la profession d'infirmière telle qu'elle s'exerce actuellement ou entrer dans une école d'infirmière telles qu'elles sont dirigées de nos jours."

Aux Etats-Unis les salaires pour une infirmière non spécialisée, payant elle-même son logement, étaient de $170 à $175 par mois en octobre 1946 et ses heures de travail étaient de 44.

Les infirmières travaillent dans les hôpitaux sous une direction autoritaire; elles sont prises entre l'autorité qu'exercent d'une part les médecins et, d'autre part, l'hôpital.

La profession d'infirmière, avec les occasions qu'elle offre d'aider ses semblables, a un grand attrait qui lui est propre, mais si nous voulons attirer des jeunes filles à faire cette oeuvre, il faut qu'elles aient en plus de la satisfaction du bien qu'elles font de meilleures salaires et des conditions de travail stables, et aussi que le milieu où elles travaillent soit débarrassé de tout excès d'autorité. Nous avons besoin de plus d'hommes comme infirmiers. Les infirmières mariées, dont les enfants sont élevés, devraient suivre un nouvel entraînement et se rendre utile. "Les étudiantes et les infirmières du personnel devraient être recrutées," dit le Dr Brown, "sans tenir compte du sexe, de l'état matrimonial, de l'origine ethnique, raciale ou de la religion et en relégant à l'arrière plan la question économique."

La solution de cet urgent problème, d'après le Dr Brown, requièrera une organisation approfondie des services de l'infirmière. Les fonctions les plus simples pourraient être exécutées par des aides entraînées et autres groupes auxiliaires sous surveillance. Celà libérera un certain nombre d'infirmières, qui pourront s'occuper alors des gravement malades et faire la surveillance.

Mais le service de ces aides devrait se limiter aux emplois qu'elles peuvent remplir sans danger et une Loi juste devrait être passée dans chaque état, si une telle Loi n'existe pas déjà, déterminant les qualifications de l'aide, tel que fait déjà pour les infirmières.

Les conditions actuelles de l'éducation des infirmières sont considérées comme le coeur du problème. "Malgré le plus grand effort d'imagination," dit le rapport, "il est impossible de concevoir l'éducation donnée dans 1,250 écoles comme une formation professionnelle. Il y a encore des centaines d'hôpitaux qui maintiennent des écoles pour profiter des services des élèves infirmières. Il y a approximativement la moitié de ces écoles qui ont moins de 100 élèves."

Lors d'une évaluation récente, faite par les services d'hygiène publique des Etats-Unis sur 602 petites écoles, 4 pour cent seulement furent jugées excellentes ou bonnes, 50 pour cent passables, et 46 pour cent médiocres ou très faibles.

Voici les recommendations faites dans ce rapport:

Que la profession d'infirmière considère l'examen officiel de chaque école, si négligée dans le passé, comme le point le plus important dans le travail qu'elle a à accomplir.

Que la liste des écoles certifiées soit publiée et distribuée; qu'une note soit inscrite sur cette liste disant que les écoles qui ne se sont pas rendues aux demandes minimum de l'association ne sont pas inscrites sur cette liste et de même celles qui ont refusé l'examen nécessaire.

Qu'une grande campagne d'éducation soit lancée à travers tout le pays, afin de rallier l'opinion publique en faveur des écoles certifiées, et afin que le public exerce une influence corrective sur les associations d'état retardataires et sur les écoles non certifiées.

Note de la rédaction: Bien que cette étude ait été faite aux Etats-Unis, elle s'applique sur bien des points aux conditions analogues existantes au Canada. Nos écoles semblent être "la poule aux oeufs d'or" de la profession. Il serait peut-être opportun de lire en entier le rapport "L'Avenir du Nursing." ("Nursing for the Future"—Russell Sage Foundation, 130 East 22nd St., New York City 10 — Prix $2.00, aux Etats-Unis).

Nursing Profiles

Eugenie Margaret Stuart has joined the faculty of the Department of Hospital Administration in the School of Hygiene, University of Toronto. Highly qualified, both by experience and post-graduate preparation, Miss Stuart, is the first nurse to be appointed to this department.

Following graduation from the Toronto General Hospital in 1925, Miss Stuart joined the staff there as head nurse on a surgical ward. In 1928, she enrolled in the course in hospital administration and teaching given at the University of Toronto School of Nursing. She returned to T.G.H. for five years as surgical supervisor and science instructor, becoming a clinical instructor in the school of nursing, University of Toronto, in 1934. Two years of active work in South Africa preceded her appointment as superintendent of the Oshawa General Hospital in 1940. In 1947, Miss Stuart completed the work for her B.S. degree in hospital administration at Northwestern University, Chicago, and accepted an appointment as assistant professor with the McGill School for Graduate Nurses, lecturing in the field of administration in schools of nursing.

Elizabeth Calhoun Logan has been appointed to the McGill School for Graduate Nurses in charge of the new course in supervision in pediatric nursing. Miss Logan will also assist with the classes in supervision in schools of nursing.

Though she was born in Indiana, Miss Logan received most of her education in Canada. After completing high school in Sault Ste. Marie, Ont., she obtained her B.Sc. degree from Acadia University, then enrolled in the school of nursing at Yale University whence she graduated in 1937, receiving at the same time her master of nursing degree. Post-graduate work in her specialty was obtained at Boston University.

Miss Logan is familiar with the affiliating school for this new course since she was head nurse on the orthopedic floor at the Children's Memorial Hospital, Montreal, for many months. After a brief experience with the Henry St. Visiting Nurse Service in New York, she became supervisor of the Neurological Unit at Children's Hospital, Boston. In 1947, she was made supervisor of the Rheumatic Fever and Nephritis Wards at Children's Memorial Hospital, Chicago.

Elvira Eveline Nordlund has been appointed an assistant inspector of hospitals with the provincial department in British Columbia. A graduate of St. Paul's Hospital,

Howard Smith, Chicago

EUGENIE STUART

ELVIRA NORDLUND

Vancouver, in 1942, Miss Nordlund served as head nurse on the medical floor there before becoming matron of the War Memorial Hospital at Williams Lake, B.C., in 1943. In 1947 she was appointed matron of the Salmon Arm (B.C.) General Hospital. Her knowledge of the management of small hospitals will be a valuable asset in her new work.

Edna Elizabeth Rossiter, R.R.C., has assumed her new duties as matron of Shaughnessy Hospital (D.V.A.), Vancouver. A 1932 graduate of Royal Jubilee Hospital, Victoria, Miss Rossiter joined the R.C.A.M.C. in 1941 and was principal matron of Pacific Command until June, 1944, when she proceeded overseas. She was successively principal matron of No. 24 and No. 12 Canadian General Hospitals, serving in England and Belgium. She was awarded the Royal Red Cross, First Class, in 1944. Upon her discharge from the R.C.A.M.C., Miss Rossiter was appointed Western Regional Nursing Consultant with the Department of Veterans Affairs. She will combine this function with her new duties. She recently completed the course in hospital administration at the McGill School for Graduate Nurses.

Prior to the war, Miss Rossiter was a supervisor at the Royal Jubilee Hospital. For two years she was assistant night supervisor, becoming supervisor of the private patients' floor in 1934.

Minnota Grinyer is now superintendent of the Scott Memorial Hospital, Seaforth, Ont. Graduating from the Niagara Falls (Ont.) General Hospital in 1930, she joined the staff of Cottage Hospital, Toronto, as operating-room supervisor. In 1936, Miss Grinyer went to Britain and took courses in operating-room technique and ward management at Guy's Hospital, London. She also studied ward management at St. Thomas's Hospital, London, and at the American Hospital in Paris. She joined the R.C.A.M.C. in 1943 and saw service in military hospitals in Canada. On her discharge from the army, Miss Grinyer planned and opened the Central Supply Service Department at the Welland (Ont.) General Hospital. For a year she was in charge of the operating-room at the Malton (D.V.A.) Hospital and, until recently, was supervisor of the operating-room at the Mt. Sinai Hospital in Toronto.

Vera Leona Graham has returned to the province of Quebec as superintendent of nurses at the Sherbrooke (Que.) Hospital. Miss Graham was formerly superintendent of nurses at the Homoeopathic Hospital, Montreal, and more recently was on the staff of the Winnipeg General Hospital whence she had graduated in 1919. Immediately following graduation, Miss Graham engaged in private duty nursing then joined the staff of the Municipal Hospitals in Winnipeg. In 1930, she became assistant superintendent of the Port Arthur General Hospital, later becoming superintendent. She enrolled in the school of nursing, University of Toronto, and received her certificate in administration in schools of nursing in 1939 going at once to the Homoeopathic Hospital. Miss Graham has always taken an active part in nursing association activities.

Vogue, London, Eng

EDNA ROSSITER

Rose Lillian King, R.R.C., is matron at the Camp Hill (D.V.A.) Hospital in Halifax. A 1925 graduate of Victoria General

MINNOTA GRINYER

SISTER MARY DE LELLIS

Hospital, Halifax, Miss King served as operating-room supervisor in several hospitals before joining the R.C.A.M.C. in 1940. Her military service included matron of No. 4 C.C.S. in England and principal matron of Military District No. 6 in Canada. She was awarded the Royal Red Cross, First Class, in 1945. She was matron of D.V.A. hospitals in Malton, Hamilton, and Kingston prior to going to Halifax.

Sister Mary de Lellis has the distinction of being the first Canadian nurse to receive her bachelor of science in radiologic technology. She has resumed her position as senior x-ray technician in the Department of Radiology at St. Joseph's Hospital, Saint John, N.B. Graduating from St. Joseph's Hospital in 1929, Sister M. de Lellis was supervisor in various divisions of that hospital before going into x-ray work. She is a charter member of the Canadian Society of Radiological Technicians and first president of the New Brunswick branch of this society. She belongs to the community of the Sisters of Charity of the Immaculate Conception.

Courtesy TCA

RITA MEYER

When the trans-Atlantic aircraft on which **Rita Ann Meyer** was stewardess took fire and burned after landing at Sydney, N.S., her training as a registered nurse was the governing factor in her ability to remain cool in an emergency and shepherd her passengers to safety. As a result, the eleven passengers and the six crew members all got safely away.

Rita Ann Meyer was born twenty-seven years ago in Kitchener, Ont. She was one

ISABELLE MILLER

Isabelle Ethel Miller, a graduate in 1941 of the Sherbrooke (Que.) Hospital, has gone to China as a medical missionary under the auspices of the Woman's Missionary Society of the United Church of Canada. Miss Miller increased her qualifications through post-graduate work at the Montreal Neurological Institute where she was employed for five years following the completion of her course. Recently she graduated from the United Church Training School, which is affiliated with Emmanuel College, University of Toronto.

of a family of seven boys and three girls, all of whom were raised in the western Ontario city and attended the schools there. An older sister, Julia, trained as a nurse and graduated from St. Mary's Hospital, Kitchener, in the class of 1932. She is now with the Victorian Order in Chatham, Ont.

It might have been Julia's example which persuaded Rita to follow the nursing profession. After finishing high school in Kitchener, she entered St. Mary's Hospital and graduated in the class of 1942. Following graduation she nursed at the Florence Crittenton Hospital in Detroit, Mich., and in the summer of 1943 went to Ottawa where she did private duty at the Civic Hospital.

The urge to travel struck her early in 1944 and she applied to Trans-Canada Air Lines for a position as stewardess. Accepted, she flew on the domestic routes of the company until the expanded trans-Atlantic services provided openings for stewardesses on international flights. Miss Meyer was one of the original trans-Atlantic group and to date has made more than ninety crossings, alternating between Montreal and Prestwick and Montreal and London. She has over five thousand hours in the air.

Congratulations were extended to **Elizabeth Russell,** director of public health nurses in the Manitoba Department of Health and Public Welfare, when she was elected a vice-president of the Canadian Public Health Association at the annual conference.

Florence E. Coleman, who was superintendent of nurses at the Saint John Tuberculosis Hospital, N.B., for twenty-eight years, has retired. High tribute was paid to the quality of her service and her faithfulness and efficiency throughout her long years in this hospital. Miss Coleman helped to build the institution to the high standard it holds today. In token of their esteem, the members of the staff presented her with a silver tea service at a large reception held in her honor. The patients supplemented this gift with an electric kettle. We hope she may long enjoy them.

Miss Coleman has taken an active part in nursing affairs, on the executive of the Catholic Women's League, the Children's Aid Society, and in Red Cross work. During the war she gave generously of her time and talents conducting classes in first aid and home nursing.

Jane Prudence Cole was the honored guest on the occasion of her alumnae's celebration of her thirty years as operating-room supervisor at the Oshawa General Hospital, Ont. Graduating from the school of nursing of that hospital in 1916, Miss Cole engaged in private duty for a year. After another year as obstetrical supervisor at Oshawa, she began her long tenure of this important office. As expressions of appreciation of her unceasing efforts and willing co-operation, Miss Cole received many beautiful gifts, including an exquisite wrist-watch, a beautiful hand-bag with a purse of money from the hospital and medical staff, and a basket of thirty roses from the alumnae association. Many congratulatory messages for her continuing happiness and success in her beloved operating theatres were received from distant friends. Miss Cole is also active in the Women's Auxiliary of the Anglican Church. Her chief hobby is selling tickets for affairs sponsored by different organizations in Oshawa!

Controlling Smallpox

Early in 1947, virulent smallpox was introduced into New York City by a merchant returning from Mexico City. As soon as the local health authorities became aware of the fact, they immediately drafted plans to vaccinate as many people in New York City as possible. Through a heroic effort and the co-operation of private physicians, pharmacists, the press, the radio, and many organizations, more than 6,000,000 people in the city were vaccinated in less than a month — more than 5,000,000 of them within two weeks. This mass vaccination program succeeded in preventing the spread of the disease beyond the twelve cases contracted before the campaign was started. The reaction of those vaccinated indicated that the number of susceptibles in the population was sufficient to have made a major epidemic possible.

— *M.L.I. Statistical Bulletin*

STUDENT NURSES PAGE

Impressions of the "Block System"

MARY LOFTUS

AS A SENIOR student nurse it is my privilege to write a few of my impressions on the new system of education in our school—the "Block System." The Holy Cross Hospital is the first in Alberta to attempt such a project and as such it is a pioneer in the plan of raising the standards of education for student nurses.

Having completed the senior block very recently, I am able to compare the old system with the new. In comparing them, let us first consider the problem of "time." With the old method, the student worked eight hours on wards and very often attended classes on her hours "off." For the supervisors as well as for the students this was a great problem. Each nurse had to have her hours arranged to correspond with her class schedule and often, when several nurses attended the same class, there was a shortage on the ward. When the department was busy it was difficult for the student nurse to finish her work in order to be on time for class. Night nurses quite often had to get up early in the afternoon to attend lectures. Needless to say, the well-prepared lectures were not always welcome or enjoyed. There was not much time for study. When we had time we were too tired to do so, therefore we lacked interest in our academic work.

Miss Loftus was a senior student at Holy Cross Hospital, Calgary, when this was written.

With the block system all this is changed. The student has classes from eight or nine in the morning until four in the afternoon with two hours free at noon. When she comes to class she is rested, her mind is open and ready to absorb what the lecturer has to say. Under the old system her mind was on the patient whom she had just left or perhaps on some work she failed to do and which must be done after class.

In the block, each subject is taught daily, therefore the interest is sustained and the student is able to correlate the work from day to day. Before, the subject was taken once a week and the nurses did not find much time to review from lecture to lecture; thus the task was more difficult for lecturers and students alike. A study period is set aside every day now. Study does not seem at all tedious when done daily. It is even enjoyable!

The school spirit is improved by increased social activities in each class, made possible by the regular hours of study and leisure. The ward spirit is also improved, thus enabling us to give better care to the patients.

To help correlate the theory and practice we have clinical instructors who, with the medical staff, are doing great work in that direction.

Results of examinations are supposed to be a valid method of determining the efficiency of a system. It is gratifying to say that these last few months' marks have shown a

definite improvement, to the satisfaction of both the students and faculty.

I wish the privilege that is mine might be extended to all the student nurses. I hope that before long all the schools of nursing will adopt the block system. It will help to alleviate the shortage of nurses thus "killing two birds with one stone," as it permits schools to take a larger enrolment every year. It will also improve the situation of the student nurses, so widely discussed in many magazines.

We Like Block Teaching

JOSEPHINE CONLIN *and* JEAN HOUGHTON

FOR SOME TIME, we had heard by the "grapevine" that the intermediate students were to have an experiment in block teaching. It sounded formidable and we were all waiting to hear more. Finally, in January of this year, we were told that all the intermediate group would leave the wards and attend class for five weeks, just as we did when we were preliminary students. The word "block" was meant to convey the fact that our lectures would run continuously for an eight-hour day over that period. It was not until we started to assemble the material for this article, that we thought to wonder why the block system was started. Upon enquiry, we were told that it was an endeavor to stimulate our interest as students, to give us physical rest, and to lighten our intermediate year. That "intermediate slump," when students seem to lose some of their ideals, is probably due chiefly to fatigue. The block system, it was hoped, would prevent this. We, the intermediates, think that hope has been realized.

During the five weeks of block teaching, lectures were scheduled from nine in the morning until four in the afternoon, with one hour off at noon. The first few days of adjustment to sedentary life for six hours a day was a little hard on a certain part of our anatomy, known as the tuberosity of the ischium. However, we soon became accustomed to this new wonder of sitting, something we had not done very often since our "probie" days. The fifteen-minute relaxation periods, mid-morning and mid-afternoon, were welcomed by everyone. We had a chance to clear our minds for the remainder of the session. Collation, consisting of hot chocolate, bread and butter, was served at this time. Those who were carefully watching their waist-line eschewed the lunch and went down to the recreation room for the inevitable cigarette. The hour from 12 to 1 not only provided us with time for lunch, but also gave us a chance to get out in the fresh air for a walk. Those who did not feel the urge for outdoor exercise had time to catch up on the latest books or some forgotten knitting. This bit of exercise and relaxation gave us renewed courage and zeal to start the afternoon session. To bring relief to the floors at their busy time, half the class helped from 7:30 to 9:00 in the morning and the other half from 4:30 to 6:00 in the evening. This hour and a half kept us, to some degree, in touch with the hospital life, brushed us up in our practical skills, and as a form of enforced exercise prevented us from putting on too many pounds.

The usual form of classes in schools of nursing seems to be the lecture method. This means student activity is limited to taking notes or just being good listeners. In our block system,

Miss Conlin and Miss Houghton are students at St. Joseph's Hospital School of Nursing, Toronto, Ont.

we had demonstrations, quiz programs, skits, and movies. The variation of routine was most welcome, and besides being helpful in regard to the particular subject under discussion we discovered much hidden talent among our class-mates. For each skit a new group was chosen and in this way general interest was maintained. One of the best demonstrations was in public health, where some of our fellow students played the part of visiting nurses and taught a new mother the "do's" and "don'ts" of bathing her baby. The movie projector equipped with sound, acquired by our school last year, was a valuable asset in our classes. Many hitherto dry and uninteresting subjects literally "came to life" with the visual aids of good films.

Each subject brought its own share of assignments but even that did not prove too burdensome as Saturday afternoons were allotted for work on these. Each student seemed to put forth every effort to make her poster or essay the best, and as it turned out (this we were later told) they were all excellent. Our projects were put on display and at the February staff meeting the graduate staff members were invited to view the results of our work. Their pleasing and complimentary comments certainly added to our own personal satisfaction.

As every student knows, there are always examinations to be written and passed. At the conclusion of our course, the bulletin board presented our time-table. Examinations were well-spaced and we had sufficient time to review our work. Results were most gratifying for us and for our teachers. The fruits of the block system proved its value at least in improved percentage. "And just imagine," we said to each other as our last examination paper was handed in, "no more class until next September. Will we ever enjoy March, April, May and June!"

We think that many advantages accrued from this experiment. The medical teaching staff commented upon the interest shown in lectures by the alertness of the group and by the variety of questions asked. For our part we found the lectures more interesting as there was a direct continuity. The lapse of a week between lectures tends to make for a lack of sequence. Also, it was noticeable that in such subjects as materia medica, diet therapy, and general medicine there was greater co-ordination. The same diseases were being discussed from different angles simultaneously. This was also true of obstetrical nursing and public health nursing. We found, too, that we were not tired and could give our whole attention to the subject matter, in contrast with previous lectures when we either rushed off the floors at the last minute or reluctantly dragged ourselves out of bed. Actually, we found being a student again a welcome change from floor duty and we all felt better for the physical rest.

Everything has some disadvantages. This was a very concentrated piece of teaching. We had to apply ourselves earnestly. Our social life was at a standstill but we took consolation from the fact that it was only for five weeks. Then, too, our days off helped. These were always on Sunday, with that previous Saturday "over-night" which we so eagerly anticipated. Another disadvantage was that we were out of things on the floors, in the sense that we had no responsibility and were a small secluded unit divorced from the hospital life which had become a part of us. For this reason, we liked the hour spent daily on hospital service.

We realize that this new venture represented much work and planning on the part of our faculty members. We sincerely hope that they will find that the results will warrant a continuance of this system in our school. *We like block teaching* and we represent the views of our fellow students. We feel that it has worked out advantageously for both staff and student body and we are looking forward to the block in our senior year.

A life spent worthily should be measured by deeds not years.—SHERIDAN.

Itineraries to Include I.C.N. — 1949

THOS. COOK & SON, Official Travel Agents for the Canadian Nurses' Association, submit the following outline of travel arrangements being made by them for members of the Canadian party. (See previous announcement regarding travel arrangements being made by the Registered Nurses Association of Ontario for their own members.)

It is pointed out, however, that the itineraries are subject to modification when steamship, train, and air schedules for 1949 are made known and as may be necessary in order to conform with official arrangements being made by the International Council of Nurses for visits to institutions, etc.

TOUR N-1

May 13	Sail from Montreal by Canadian Pacific Steamship.
May 20	Due to arrive Liverpool. Continue by train to London.
May 21 through May 26	**London.** One day city sightseeing; one day Hampton Court, Eton, Windsor Castle, etc.
May 27	Train to Leamington.
May 28	Shakespeare Country Drive.
May 29	Train to Chester.
May 30	North Wales drive by motor-coach.
May 31	By train to Lake District.
June 1	Motor-coach tour through the Lakes.
June 2	Train to Glasgow.
June 3	**Glasgow.** Half-day city sightseeing.
June 4	To Edinburgh by motor-coach via Lakes and Highlands.
June 5 through June 7	**Edinburgh.** Half-day city sightseeing; one day Melrose, etc.
June 8	By train to Newcastle and sail on Bergen Line steamer.
June 9	Arrive Bergen.
June 10	To Oslo.
June 11	**Oslo.** Half-day city sightseeing. Evening train (with sleeping berth) to Stockholm, arriving on morning of June 12.
June 12 through June 16	**Stockholm.** Attending International Congress of Nurses.
June 17	Train to Copenhagen.
June 18	**Copenhagen.** Half-day city sightseeing.
June 19	Leave by train (with sleeping berth).
June 20	Arrive Amsterdam.
June 21	**Amsterdam.** City drive and Marken excursion.
June 22	Train to Brussels.
June 23	**Brussels.** Half-day city sightseeing. Leave by afternoon train for Paris.
June 24 through June 27	**Paris.** One day city sightseeing; one day to Versailles and Malmaison.
June 28	Leave Paris by night ferry (with sleeping berth).
June 29	Arrive London and continue by train to Liverpool and sail on Canadian Pacific Steamship.
July 6	Due to arrive Montreal.

Note: *Opportunities will be offered for members to join other Escorted Tours leaving Paris for Switzerland, Italy, the Riviera, etc.*

TOUR N-1A

For those having insufficient time to visit England before the Congress, arrangements can be made to leave Montreal by Canadian Pacific Steamship on May 27 to Liverpool, thence train to London, arriving June 3, spending the time from June 3-7 in London, travelling to Newcastle on June 8 to join the members of Tour N-1.

TOUR N-1B

May 27	Sail from Montreal by Canadian Pacific Steamship.
June 3	Due to arrive Liverpool and continue by train to Leamington.
June 4	Shakespeare Country Drive. Evening train to London.
June 5 through June 8	**London.** One day city sightseeing; one day Hampton Court, Eton, and Windsor Castle.
June 9	Train to Tilbury and sail on Swedish-Lloyd steamer.
June 10	At sea.
June 11	Arrive Gothenburg. Continue by train to Stockholm and join members of Tour N-1.

TOUR N-2

May 13	Sail from Montreal by Canadian Pacific Steamship.
May 20	Due to arrive Liverpool. Continue by train to Leamington.
May 21	Shakespeare Country Drive. Evening train to London.
May 22 through May 27	**London.** One day city sightseeing; one day Hampton Court, Eton, and Windsor Castle.
May 28	London to Paris by day service.
May 29 through *June 3*	**Paris.** One day city sightseeing; one day to Versailles and Malmaison.
June 4	Morning train to Brussels. Afternoon city sightseeing.
June 5	**Brussels.** Leave by afternoon train to Amsterdam.
June 6-7	**Amsterdam.** Half-day city drive and half-day excursion to Volendam, etc.
June 8	Leave Amsterdam by train (with sleeping berth).
June 9	Arrive Copenhagen.
June 10	**Copenhagen.** Half-day city sightseeing.
June 11	Train to Stockholm.
June 12 through June 17	**Stockholm.** Attending International Congress of Nurses.
June 18	To Karlstadt by motor-coach.
June 19	To Oslo.
June 20-21	**Oslo.** Half-day city sightseeing.
June 22	Continue to Geilo.
June 23	To Granvin by motor-coach.
June 24	Continue by motor-coach to Bergen.
June 25	Sail in afternoon by Bergen Line Steamship.
June 26	At sea.
June 27	Arrive Newcastle, thence by train to Lake District.
June 28	**Lake District.** Day circular drive by motor-coach.
June 29	To Liverpool by train and sail by Canadian Pacific Steamship.
July 6	Due to arrive Montreal.

Note: *Members will have the option of leaving the tour on arrival at Newcastle on Monday, June 27, proceeding to Edinburgh for a tour of Scotland, English Lake District, or to visit Ireland before returning to Montreal.*

Tour N-1. INCLUSIVE FARES

$1,347—with minimum rate round trip first-class accommodation on Atlantic steamers (valued at $480).

$1,171—With minimum rate round trip tourist class accommodation on Atlantic steamers (valued at $304).

Tour N-1B:

$1,095—With minimum rate round trip first-class accommodation on Atlantic steamers (valued at $480).

$919—With minimum rate round trip tourist class accommodation on Atlantic steamers (valued at $304).

Tour N-2:

$1,250—With minimum rate round trip first-class accommodation on Atlantic steamers (valued at $480).

$1,074—With minimum rate round trip tourist class accommodation on Atlantic steamers (valued at $304).

All rates quoted are based on steamship, transportation, hotel rates, etc., in effect at the present time, are subject to change without notice, and bookings are accepted subject to conditions to be specified in final program.

The fares provide: Third class travel in Great Britain and second class travel on the Continent; first class on local steamers. Reserved seats are provided for day travel and sleeping-car berths for night travel, where available. Beds in double rooms (without baths) at good, comfortable hotels.

All meals, except in London, Stockholm, and Paris, where breakfast only is provided; tips and fees; transfer of passengers and two pieces of hand-baggage; sightseeing; services of Tour Manager from port of arrival to port of departure in England, in accordance with full details which are to be announced in our Convention Tour Program, which will be published as soon as possible after 1949 schedules have been determined.

Owing to the general shortage of steamship, hotel accommodations, etc., membership with each tour is limited.

A **deposit of $100** is required at time of booking. Final payments must be made six weeks before departure date from Canada, or upon request.

For reservations or further information write:

Mr. R. F. Cummings, Branch Manager, Thos. Cook & Son Ltd., 1241 Peel St., Montreal 2, Que.

A sound mind in a sound body is a short but full description of a happy state in this world. — Locke.

Book Reviews

Introduction to Psychiatry, by W. Earl Biddle, M.D. and Mildred van Sickel, B.S., R.N. 344 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1948. Illustrated. Price $3.25.

Reviewed by Nessa Leckie, Supervisor, Psychopathic Hospital, Winnipeg.

The approach to the problem of psychiatric nursing is especially important. The correct attitude of the student nurse towards the care of the mentally ill is an essential factor in the treatment of the patient. In this text, the special problems which occur in the care of the psychotic patient are clearly emphasized.

For the student nurse who requires a foundation in psychiatric nursing this text provides a sound basis for further study. The chapters on Special Therapies and Symptomatology can be applied in teaching student nurses, ward aides or attendants.

Unit IV, which deals with the Functional Psychoses, defines the psychoses and cites a case history of each type which is especially helpful to the student in general hospital who does not have the opportunity of seeing many cases.

This edition differs from the first in that each chapter closes with a section on nursing problems, which serves as a review of the chapter and an aid to setting tests.

Suggestions for further reading are provided at the end of each chapter; a brief glossary of psychiatric definitions is added at the end of the book.

Nursing in Tuberculosis, by Louise Lincoln Cady, R.N. 481 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1948. Illustrated. Price $4.00.

Reviewed by Elsie J. Wilson, Tuberculosis Nursing Consultant, Bureau of Public Health Nursing, Man.

This book is intended primarily for the nurse, student or graduate, whose knowledge of tuberculosis is limited. It is very comprehensive in scope and covers the care of the tuberculous patient from the time of diagnosis to the point of rehabilitation.

Nursing care, in all treatments of the tuberculous, is discussed in detail. The many opportunities for teaching patients, relatives, and friends on the ward, in the clinic, and in the home are stressed. There is a valuable chapter on the relationship between public health nurse, social worker, and health educator which is sensible and timely. The nurse must learn to welcome and use wisely the services of others in this vast field. The review questions at the end of each chapter are helpful and stimulating.

This is a book which should be in the library of every school of nursing and also every public health organization.

Hearing and Deafness — a Guide for Laymen, by Hallowell Davis, M.D. 488 pages. Published by Murray Hill Books, Inc., Toronto. Price $6.00.

Reviewed by Harriette S. Wilson, public health nurse, Kitchener, Ont.

This would be a valuable book for public health nurses and others interested in the hearing problems of children and adults. Of this book, John Tracy, of the John Tracy Clinic, says: "Here, at last, is information correct, easy to read."

In the introduction, C. Stewart Nash, president, American Hearing Society, says: "One can find reliable answers to such questions as: Why did I lose my hearing? Is my deafness bad enough to require a hearing aid? Should I buy a bone conduction or air conduction instrument? In which ear should I wear the aid?" Or of problems regarding a congenitally deaf child: "Why doesn't my child talk? What about his education? Will the fenestration operation cure my deafness?"

The illustrations are very good and the material well arranged. The book is divided into six parts: Audiology; hearing and hearing aids; auditory tests and hearing aids; rehabilitation for hearing loss; education and psychology; social and economic problems.

The Aseptic Treatment of Wounds, by Carl W. Walter, A.B., M.D. Illustrated by Mildred B. Codding, A.B., M.A. 372 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Price $9.00.

Reviewed by Mary Warnock, Operating-room Supervisor, Royal Victoria Hospital, Montreal.

The book has within its pages information of the greatest value to everyone connected with the surgical care of patients whether it be surgeon, nurse, or layman, simplifying and standardizing aseptic techniques on a scientific basis. Every step of each treatment is clearly portrayed by line drawings.

The first section of this book thoroughly deals with sterilization — both physical and chemical — and, by the use of graphs and diagrams, clarifies technical points which emphasize the basic principles involved rather than collected data. The second portion deals with the preparation of materials used in various aseptic procedures, with a series of excellent diagrammatical illustrations demonstrating the uses of these and contrasting the correct and incorrect methods. Following is a very clearly illustrated section on posturing and draping. The last section is devoted to the planning, management, and technique of a Blood Bank and Central Supply Room, giving excellent illustrations of both procedures and equipment, and ending with a very instructive chapter on communicable disease control.

This is an exceptionally good book in which an endeavour is made to correlate the knowledge and efforts of all who assist in the aseptic treatment of wounds.

Surgical Nursing, by E. L. Eliason, M.D., L. K. Ferguson, M.D. and E. M. Farrand, R.N. 585 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 8th Ed. 1947. Illustrated. Price $4.00. *Reviewed by Ruth Leavens, Toronto General Hospital, Ont.*

This is a revised edition of an excellent surgical nursing text with which many nurses are already familiar. The general set-up of the book has changed very little from the previous edition, the arrangement following the same well-organized pattern. Just sufficient information about disease and treatment is given to make easily understandable the nursing care. The principles of nursing care are covered — details will have to be added by the individual instructor.

In the revision, the authors have incorporated some of the most recent medical advances, such as the ever-changing conception of shock and its treatment, and the recent trend in early post-operative ambulation. Also worthy of mention is the revised chapter on the vascular system. One would feel, however, that more might have been said about the recent strides in the treatment and rehabilitation of the paraplegic patient.

The necessity for the inclusion in a surgical nursing text of such basic procedures as hypodermic injection and catheterization is questionable.

The reviewer's feeling is that the book would be a valuable addition to any reference library.

New Zealand Nursing News

A new course is reported in *The New Zealand Nursing Journal* where registered nurses may secure training "to enable them to take positions as supervisors of housekeeping and kitchen activities" in nursing homes or in small hospitals where no dietition is employed. The graduates from this course would be qualified to instruct first-year student nurses in the essentials of cookery but would not be permitted to undertake the advanced theoretical instruction in nutrition and diet therapy. It is planned that the course will include both theory and practice, covering such useful information as: menu-making, recipe-making and the altering of recipes, different cuts and grades of meat, storage problems, quantity cookery methods, wastage control, etc. The course covers a period of eighteen weeks.

Governmental sanction for hospital employment regulations was secured, based on proposals submitted by the New Zealand Registered Nurses' Association. The most important point gained is that "salaries, emoluments, and conditions of employment are now mandatory. Nurses will no longer be dependent on the generosity or otherwise of individual hospital boards for the payment of the recommended salaries and allowances, and the provision of their complete uniform." "Provision is made for the payment of a percentage of the salary for those hours of duty in excess of forty, which are *usually worked* by the nurse during the week." There is no suggestion that actual record be kept of extra minutes spent to finish up some piece of nursing duty, but where staff shortages necessitate some additional time on duty the nurses will be paid on a pro rata basis. The association is recognized as the official bargaining body in any disputes regarding nurses' salaries or working conditions.

for **soft smooth hands** that people admire...

morning

noon

AND night

Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

With* TRUSHAY *that is.

For TRUSHAY starts off by being the most luxurious softener that ever smoothed your skin—rich as cream—but without a trace of stickiness. It's sheer delight to use at any time.

And that isn't all.

For TRUSHAY does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, TRUSHAY protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

Begin today to use TRUSHAY—and when patients admire your well-groomed hands, tell them about the lotion with the

"beforehand" extra—

TRUSHAY

Product of **BRISTOL-MYERS COMPANY OF CANADA LTD., - 3035 St. Antoine St., Montreal 30, Que.**

Irish Nursing News

Eire Anti-tuberculosis drive: Speaking recently, the Eire Minister of Health (Dr. Noel Browne) stated that there are twenty-five thousand tuberculosis patients in Eire and that three thousand die of tuberculosis annually. He is doing his utmost to increase the inadequate sanatorium facilities by temporarily taking over virtually redundant Protestant schools, and general hospitals, and hopes to wipe out this national scourge by 1953. The new general hospital at Mallow, County Cork, is to become a sanatorium temporarily. Cork is to have a new £1,000-000 general hospital with some 420 beds.

Later this year, the reconstructed and re-occupied St. Raphael's Preventorium, Cork, (for incipient tuberculosis cases) will be ready.

Dr. Noel Browne announced in the Dail recently that his department will spend approximately £15,000,000 during the next seven years on hospital construction.

Dr. Noel Browne is launching a hygiene publicity campaign for the benefit of the less educated section of the public and hopes that this propaganda will, besides promoting greater personal cleanliness, greatly reduce the high tuberculosis and gastro-enteritis figures.

Congenital Malformations

Congenital malformations ranked third as cause of death among infants under one year in Canada in 1947. The mortality rate was 575 per one hundred thousand live births. The etiological causes of congenital malformations may be divided into two main groups: (a) The hereditary, resulting from defects in the normal chromosomal pattern. (b) The acquired, resulting from the clinical occurrence of disease in the female during the period of gestation.

In the majority of the so-called civilized nations, marriages are usually arranged without the slightest consideration of the family pedigree of either the male or the female partner. The descendants of individuals having known congenital abnormalities are permitted to become united in wedlock. The result is the constant reproduction of affected individuals unless a lethal effect is produced by the union. The prevention of the continued passage of congenital abnormalities is possible, but because of our customs and beliefs exceedingly difficult. The assurance of as normal an heredity as possible for each child is not only a challenge to preventive medicine, but the basis of the constructive program of this science. We must plan, build, and maintain health as well as prevent the introduction of disease and provide for remedial action when this occurs. The average lay individual has no conception of the etiology of inherited congenital defects. An intensive educational program is an acute necessity. Preventive medicine's task might be visualized as advising those who are contemplating marriage regarding their pedigrees.

The acquired congenital defects may be prevented by the construction and maintenance of maternal health. Given a healthy mother of good heredity, the most probable result is a healthy baby. However, prevention of disease must play a role here. Certain of the contagious and infectious diseases may occur coincident with pregnancy. This may result in abortion or the development of congenital lesions and the maldevelopment of the fetus. German measles is an outstanding offender when infection develops during the first three months of pregnancy. The result is a 50 per cent probability of abortion and a further 50 per cent probability of the development of congenital malformations of the fetus if the pregnancy continues to term.

Until safe and potent methods of immunization against measles, German measles, mumps, and poliomyelitis have been developed the complete eradication of the acquired congenital abnormalities is not possible. Advances are being made in the development of a safe immunizing agent against poliomyelitis. The announcement of the development of a concentrated virus vaccine for mumps has recently been made. A high degree of protection against measles, German measles, and mumps may be obtained through the development of natural active acquired immunity by planned exposure and the occurrence of infection between the sixth and tenth years of life. The maintenance of a high active, immunity, artificially acquired through immunization, will solve this problem relative to the other infectious diseases, except syphilis. The education of our population

in personal and sex hygiene, the early diagnosis of infections, and the immediate introduction of modern methods of treatment will greatly reduce the occurrence of congenital syphilitic lesions. —*Selected*

Visitors

First winners of Rockefeller scholarships for Korean nurses, Miss Sook Kyung Lee, centre, and Mrs. Oak Soon Hong, right, are shown their travel orders to the United States and Canada by their adviser, Capt. Myra H. Heeren, left, Creston, Ia., prior to their departure. Miss Lee, a Department of Education Nursing consultant, will study teaching and administration techniques at the University of Toronto School of Nursing, and Mrs. Hong, a Nursing Affairs director, will tour public health nursing sections in Baltimore, Md., Washington, D.C., Toronto, and New York City.

Alberta

The following are staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Augusta Evans*, assistant director of the Division of Public Health Nursing, will serve as acting director during *Jean Clark's* absence on the Public Health

Busy feet

. . . stay alert without tiring when they are comfortably shod in walk-easy (and that means miles and miles a day).

Blachford Nurses' Special Shoes
MADE BY
THE BLACHFORD SHOE MFG. CO. LTD.
3543 Danforth Ave. Toronto

NURSES' SPECIAL

Sold in better stores from coast to coast.

THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing, with or without experience.

Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Dorothy M. Mickleborough
Acting Chief Superintendent
193 Sparks Street
Ottawa.

THE CENTRAL REGISTRY OF GRADUATE NURSES, TORONTO

Furnish Nurses
● at any hour ●
DAY or NIGHT

TELEPHONE **Kingsdale 2136**

Physicians' and Surgeons' Bldg.,
86 Bloor Street, West, TORONTO 5.
WINNIFRED GRIFFIN, Reg. N.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA
(Incorporated)

An examination for the title and certificate of Registered Nurse of British Columbia will be held on January 18, 19, 20, and 21, 1949.

Names of candidates for this examination must be in the office of the Association not later than December 18, 1948.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar,
1014 Vancouver Block, Vancouver, B.C.

Survey Committee in Alberta. *Blanche Emerson*, formerly nurse in charge of the Edmonton Child Welfare Centre, and a previous acting director with the division, is relinquishing her retirement for a temporary period to become acting assistant director.

Edith Batten (Whitehaven and West Cumberland Hospital, Eng.; C.M.B. at Plaiston's Hospital, London) is at Lomond. Miss Batten served for a number of years as a Queen's Nurse in England and with the Frontier Nursing Service in Kentucky. *Katherine Ambrose* (University of Alberta degree course in nursing) is at Alder Flats.

Return from Leave of Absence: *Jean Blackbourne* is now at Hines Creek. Miss Blackbourne obtained her public health nursing diploma at the University of Western Ontario. *Katherine Brandon* is located at Hilda. Miss Brandon obtained her public health nursing diploma at the University of British Columbia.

Transfers: *Mrs. E. A. Bennett* from Hines Creek to Vauxhall; *Mrs. K. P. Cole* from Alder Flats to Whitecourt; *Ethel Jones* from Vauxhall to Sunnynook; *Angela McIntosh* from Hilda to Breynat.

Leaves of Absence: *Laura Attrux*, formerly of Whitecourt, and *Mrs. C. J. Somerville*, formerly of Kinuso, are on a four-month leave of absence to take the course in advanced practical obstetrics at the University of Alberta. *Mary Anderson*, Bonanza, has been granted a year's leave to take the public health nursing course at University of Alberta.

Resignations: *Mrs. Jean Doolan* of New Brigden; *Muriel Sweetnam* of Youngstown to be married; *Marguerite Fitzsimmons* of Youngstown.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Mrs. Margaret Outtier* (Toronto General Hospital and University of Toronto certificate course), formerly public health nursing supervisor, Etobicoke Township board of health, as supervisor, Halton County health unit, succeeding *Jennette Gillespie* (Hospital for Sick Children; U. of T. cert. course; McGill University administration and supervision course) who is pursuing post-graduate study; *Ruth Kent* (B.Sc.N. degree, U. of T.) as public health nursing supervisor, Etobicoke Township board of

THE CREAM *with many uses*

Nivea Creme should have a permanent place in every nurse's cupboard. It serves all cosmetic purposes and also has valuable soothing properties. Nivea is different from other creams because it contains Eucerite, a substance that closely resembles the skin's natural fatty elements. Aided by Eucerite, Nivea penetrates the epidermis and feeds back into the skin the nourishing elements taken out by washing, antiseptic fluids, chafing and daily wear and tear. For very dry skins, and for massage, use Nivea Skin Oil.

Skin needs NIVEA

FOR SKIN-HEALTH AND BEAUTY

Manufactured in Canada by
NIVEA PHARMACEUTICALS LIMITED
Distributing Agents VANZANT & COMPANY
357 College Street, Toronto

'Nivea' and 'Eucerite' registered Trade Marks

(C.31)

health; *Eileen McCready* (Montreal General Hospital and McG. U. cert. course) and *Marie J. Ford* (M.G.H. and McG. U. cert. course) Kirkland-Larder Lake health unit; *Jane Minott* (Toronto Western Hospital and U. of T. cert. course), formerly with Prescott and Russell health unit, Oshawa board of health; *Bernice Seeds* (T.W.H. and B.N. degree, McG. U.) Northumberland and Durham health unit; *Lenna Fraser* (Ont. Hospital, London, and U. of T. cert. course), formerly with Northumberland and Durham health unit, Kent County health unit; *Fayletta Bateman* (B.Sc., University of Western Ont.) London board of health; *Helen Rush* (Victoria Hospital, London, and U. of W.O. cert. course) and *Lorraine McMullen* (Royal Victoria Hospital, Montreal, and University of Ottawa public health course) St. Catharines-Lincoln health unit; *Florence Watson* (H.S.C. and U. of T. cert. course) Wentworth County school health service; *Marjorie Armour* (Hamilton General Hospital and U. of T. cert. course), formerly with Peterborough board of health, Halton County health unit; *Mrs. Norman (Mountain) Gainer* (Guelph General Hospital and U. of T. cert. course), formerly with Welland and district health unit, Peterborough board of health; *Mrs. Noreen Heath* (Royal Southern Hospital, Liverpool, Eng. and U. of Pennsylvania public health course) Hamilton board of health.

Resignations: *Helen Mackay* (T.G.H. and McG. U. public health course) and *Janet Folster* (H.S.C. and U. of W.O. cert. course) from Oxford County health unit, the former to pursue post-graduate study; *Mrs. W. J. Shapter* (H.G.H. and U. of W.O. cert. course) from Elgin-St. Thomas health unit; *Kathleen Abbott* (Wellesley Hospital, Toronto, and U. of T. cert. course) and *Audrey Lamb* (R.V.H., Montreal, and U. of T. cert. course) from Kent County health unit; *Janet Kirkland* (V.H., London, and U. of W.O. cert. course) from St. Catharines-Lincoln health unit.

The following public health nurses will enrol in the advanced course in administration and supervision in public health nursing at the U. of T.: *Carrie Genik* (Royal Alexandra Hospital, Edmonton, and U. of T. cert. course) from St. Catharines-Lincoln health unit; *Helen Fasken* (H.G.H. and U. of W.O. cert. course) from Kirkland-Larder Lake health unit; *Lorraine Larsen* (St. Michael's Hospital, Toronto, and U. of T. cert. course) from Halton County health unit; *Miriam MacDonald* (T.W.H. and U. of T. cert. course) from North Bay board of health; *Mrs. Gert-*

ROYAL VICTORIA HOSPITAL
SCHOOL OF NURSING
MONTREAL
COURSES FOR GRADUATE NURSES

1. A four-month course in **Obstetrical Nursing.**
2. A two-month course in **Gynecological Nursing.**

For further information apply to:
Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. Q.
or
Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

TWO-MONTH POST-GRADUATE COURSE IN THE IMMUNOLOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS.

This course is especially valuable to those contemplating Public Health, Industrial, or Tuberculosis Nursing.

For further information apply to:

Superintendent of Nurses, Mountain Sanatorium, Hamilton, Ontario.

rude Purcell (T.G.H. and U. of W.O. cert. course) from Perth County school health service.

M.L.I.C. Nursing Service

Apolline Coursol (Hôtel-Dieu, Montreal) and *Alice Comtois* (Sacred Heart Hospital, Cartierville) have been granted scholarships by the Metropolitan Life Insurance Company to attend the School of Public Health Nursing, University of Montreal. *Simone Beauregard* (Ste. Jeanne d'Arc Hospital, Montreal, and U. of M. public health course) is now on the Montreal staff. *Rossie Densmore* (Plummer Memorial Hospital, Sault Ste. Marie), for many years in charge at Sault Ste. Marie, has resigned from the company's service.

News Notes

BRITISH COLUMBIA

ABBOTSFORD:

Eighteen members were present at a recent meeting of Matsqui-Sumas-Abbotsford Chapter, when the new president, Mrs. Mae Tucker, was in the chair. Chapter plans include an autumn tea. The evening's raffle, a box of correspondence cards, netted $1.70 and was won by Miss Irwin.

Some of the members attended the district meeting held at Mission.

Vancouver General Hospital:

Graduates enrolled for the post-graduate course in operating-room technique and supervision include: Dora Sewell (Port Arthur General Hospital); Joyce Robinson (Royal Jubilee Hospital); Magdalen Boyes (V.G.H.); Jean McCulloch (V.G.H.); Dorothy Curle (St. Eugene Hospital, Cranbrook); Mrs. Nora McColm (Medicine Hat General Hospital).

F. Wright, G. Walker, E. Curtis, L. Hurst, K. Templeton, T. Longair, and D. Pearce, all recent graduates, are now on the operating-room staff. Mrs. A. (Holmes) Kidd, who has completed the O.R. course, is also on the staff.

MANITOBA

BRANDON:

Isabel Lightly, Halifax, and Mrs. Marion Hannah, Brandon, have been appointed as senior supervisors at the General Hospital. Nellie Martin and Edith Anderson are on the teaching staff of the school of nursing. Phyllis Laird is now dietitian.

NEW BRUNSWICK

FREDERICTON:

The first autumn meeting of Fredericton Chapter was held recently, with the president, Shirley Grant, in the chair. Evelyn Wood was appointed program convener to fill the vacancy caused by the resignation of Evelyn Carlisle, who has left to reside in Vancouver. Plans were made for rummage and fancy work sales. The registry report showed that the Victoria Public Hospital registry now has a large number of nurses in good standing. Boxes are to be sent to nurses in Great Britain, as in the past two years, with Edith Warman and Marion Brewer serving on the Overseas Box Committee.

The chapter, hostess to the provincial association during the annual meeting in September, had the following members in charge of arrangements: Shirley Evans (convener), E. Harvey, D. Parsons, A. Charters, D. Crawford, and E. Bell.

A social hour concluded the meeting when refreshments were served under the convenership of Marjorie Burtt, assisted by Misses Brewer, Parsons, Linton, and Ashworth.

Regret was expressed at the departure of Miss Evans from the city. Formerly an active member of the chapter, she has entered the public health field in Westmorland County.

Victoria Public Hospital:

The following resignations have taken place: Gladys Tomilson, head nurse, children's ward, to go to Vancouver; Norah Lenihan, head nurse, maternity department; Mary Boyd, night supervisor; Doris Crawford, assistant operating-room supervisor, who recently married. Marion Brewer replaces Isabel Lane in the teaching department. Miss Lane is working with the public health service of the province.

SAINT JOHN:

General Hospital:

Elspeth Menzies, president of the junior class of the training school, introduced the new probies on the eve of their arrival to the members of her class at an informal pyjama party.

Margaret Saunders and Inez Shortliffe are doing general duty in Medicine Hat, Alta., while Betty Walker is in Waterbury, Conn. Ruth Thomson is taking post-graduate work in public health at the University of Toronto.

St. Joseph's Hospital:

Sr. Helen Marie, a graduate of Holy Family Hospital, Prince Albert, Sask., is now superintendent of nurses. Sr. Marie has her B.Sc. in nursing education from St. Louis University.

Twenty probationers were received recently into the training school. Miss Chlow resigned from the staff to be married and the

LAW AND THE PRACTICE OF NURSING

By Nettie D. Fidler and Kenneth G. Gray. This authoritative book discusses both the legal privileges and the legal responsibilities of the nurse. To safeguard her position, every nurse should be familiar with this information. A copy of the book will prove invaluable for reference in the nursing library. 112 pages, 1947. $2.00.

MEDICAL ETHICS FOR NURSES

By Charles J. McFadden, Villanova College, Pennsylvania. Written from the Catholic point of view this book is proving extremely popular. The fifteen chapters include: contraception, direct abortion, sterilization, assistance at immoral operations, truthfulness and professional secrecy, etc. 372 pages, third printing, 1947. $3.75.

THE RYERSON PRESS
TORONTO

REGISTRATION OF NURSES

Province of Ontario

•

EXAMINATION ANNOUNCEMENT

•

An examination for the Registration of Nurses in the Province of Ontario will be held on **November 24, 25 and 26.**

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

The Director,
Division of Nurses Registration
Parliament Buildings, Toronto 2

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PREVENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary—$104.50 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

McGill University School for Graduate Nurses

—Degree Courses—

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

—One-Year Certificate Courses—

Teaching and Supervision in Schools of Nursing.
Administration in Schools of Nursing.
Supervision in Psychiatric Nursing.
Supervision in Obstetrical Nursing.
Supervision in Pediatric Nursing.
Public Health Nursing.
Administration and Supervision in Public Health Nursing.

For information apply to
School for Graduate Nurses
1266 Pine Ave. W.
McGILL UNIVERSITY, MONTREAL 25

new nursery supervisor is now Rita O'Hara. Miss McInnis is doing general duty in New York.

Srs. Marie de Lourdes and Rosarie attended the annual convention in Fredericton, while Misses Porter and Hayes represented the student body.

ST. STEPHEN:

At the annual meeting of St. Stephen Chapter, held at the home of the president, C. Darling, all officers and committee conveners were re-elected, with the exception of *The Canadian Nurse* convener, Mrs. F. McGarrity. Her place has been filled by A. Mark. At the business meeting, which was preceded by a picnic supper, reports were delivered by all officers on the year's activities. A Sick Nurses' Benefit Fund has been established for the coming months. Tickets were distributed for a raffle on a blanket, the proceeds to be donated to this fund. Myrtle Dunbar, one of four delegates to the C.N.A. convention, gave a comprehensive account of this meeting. Twelve chapter members attended the N.B.A.R.N. meeting held at Fredericton.

Sybil Bannister is relieving Rheta Smith, who has been married, as supervisor, men's ward, Chipman Memorial Hospital.

NOVA SCOTIA

HALIFAX:

Edna MacDonald, Ethel Gunn, and Mrs. Gertrude Smith recently resigned from the public health field nursing staff. The public health committee approved a recommendation for the appointment of Barbara June LeLievre and E. Louise Hattie.

Children's Hospital:

Ruth Bailey of Toronto and Gwennyth Barton of Halifax, first two Negro nurses to graduate from a school of nursing in Canada, recently received their diplomas at the graduation exercises held here.

ONTARIO

DISTRICT 4

NIAGARA FALLS:

The Niagara Peninsula Chapter acted as hostesses on the occasion of a meeting of the district held following an enjoyable picnic. Anna Oram, district chairman, presided. Plans of the provincial committee and the joint committee on legislation were considered and an outline of information was drawn up. It was planned to bring the proposed Bill for the Ontario Nurses' Act to the attention of the members of the Ontario Legislature immediately. The association has a Draft Bill for the Nursing Act and hopes that the Minister of Health will be willing to present it to the Legislative Assembly at its next session. The association feels that it should receive

recognition as a professional group by being responsible for the standards of its practice. It is planned to approach the various service groups and clubs with regard to this act.

Members of the Legislation Committee for the district include: Helen Brown (St. Catharines General Hospital); Catharine A. O'Farrell (Niagara Peninsula Chapter chairman); Mrs. S. Lynn (St. Catharines).

District 5

TORONTO:

Audrey Congram recently left to take a position as assistant matron in a United Church mission hospital on Harrington Island in the Gulf of St. Lawrence.

District 8

Ottawa General Hospital:

Thérèse D'aoust (1939) has recently been appointed to the staff of nursing councillors with the Department of National Health and Welfare at Ottawa. Previous to this appointment Miss D'aoust had been employed for two and a half years on the general duty staff at O.G.H. She resigned this position to become assistant technician, Food and Drugs Laboratory, with the Department of National Health and Welfare, serving for six and a half years. During this time she also rendered first aid to the employees of this division.

The following graduates of the 1948 class were awarded prizes: First prize in nursing practice for highest standing in nursing practice throughout the course (donated by Ladies Auxiliary, O.G.H.)—Cecelia Cashman; Campbell Scholarship for highest standing in theory and practice of pediatric nursing in second year (donated by Dr. G. A. Campbell, chief, pediatric service, O.G.H.)—Mary Berthe; Florence Memorial Scholarship for general proficiency during course (donated by M. Jack Florence)—Emmanuelle Marc; Casgrain and Charbonneau Scholarship for second highest standing in theory and practice throughout the course (donated by Mr. André Gaulin, pharmacist, and professor of pharmacology at the school of nursing)—Bernadette McCoy; prize for proficiency in nursing practice for highest standing throughout course (offered by l'Amicale des Anciennes Elèves)— Sr. Bernadette du Rosaire.

District 9

Margaret E. Kerr, editor and business manager of *The Canadian Nurse*, recently honored this district by conducting a lecture tour. This tour included the chapters at North Bay, Kirkland Lake, Timmins, Sudbury, Sault Ste. Marie, and the nurses' group at Parry Sound, as well as the combined groups of Cobalt, Haileybury, and New Liskeard.

Miss Kerr's lectures gave the nurses of northern Ontario a most enlightening picture of nursing today, with emphasis on public relations. Evidence of the appreciation of Miss Kerr and of the realization of the value of the *Journal* in keeping the nurses so far north up to date in nursing affairs was shown in a $302 increase in subscriptions.

The cleaner to choose for "SNOW WHITE" shoes!

Your white shoes really take on that *spotless, immaculate* look—when you clean them with 2 IN 1 WHITE CLEANER. (All good grocers and druggists feature 2 IN 1). Handy applicator with every bottle.

Baby's Cold

Clear Baby's head and nose with gentle Mentholatum. Quickly relieves nasal distress and soothes inflamed nostrils. Helps Baby breathe freely again. Jars and tubes

A3

MENTHOLATUM

Gives COMFORT *Daily*

QUEBEC

MONTREAL:

Children's Memorial Hospital:

D. Parry and M. Cochran attended the

CHEMISTRY IN NURSING

By Raymond E. Neal, Associate Professor of Chemistry, Simmons College, Boston, Mass.

The material in this clear and straightforward text is organized in 16 units, each consisting of two or three chapters of text, a review exercise, and a group of laboratory experiments. The essentials of both inorganic and organic chemistry are covered and physiological chemistry is integrated throughout. The practical applications cited have been chosen almost entirely from everyday nursing practice, based on the author's long experience as a teacher of student nurses. **Price $4.40**

Special catalogue of "Texts and Reference Books for Nurses" available upon request.

McGRAW-HILL COMPANY OF CANADA LIMITED

12 Richmond St. E. Toronto 1, CANADA

HIGHLY NUTRITIOUS

MILDLY LAXATIVE

THAT ALL UNIFORMS CLOTHING AND OTHER BELONGINGS ARE MARKED WITH

CASH'S Loomwoven NAMES

Permanent, easy identification. Easily sewn on, or attached with No-So Cement. From dealers or CASH'S, 38 Grier St., Belleville, Ont.

CASH'S: 3 Doz. $1.65; 9 Doz. $2.75; NO-SO NAMES: 6 Doz. $2.20; 12 Doz. $3.30; 25c per tube

C.N.A. biennial meeting in Sackville. Miss Cochran has been granted leave of absence to attend the McGill School for Graduate Nurses.

New appointments include: C. Moorhead (Wesley General Hospital); Mrs. N. Franklin (Great Ormond St. Children's Hospital, London, Eng.); E. Lynge (Copenhagen, Denmark); M. Allanach (J.H.H.); C. Martin (Reddy Memorial Hospital Montreal); G. Blaney (Cornwall General Hospital). The following nurses have resigned: S. MacPherson, M. Loucks, B. Jeffrey, C. Reashor, D. Dure.

Jewish General Hospital:

An executive meeting of the Associate Nurses was held recently when the agenda for the coming year was planned. Mrs. S. Axelrod, program chairman, is planning several meetings with interesting guest speakers. A dance will be held next February. The second annual dinner took place in October.

Montreal General Hospital:

At the opening fall meeting of the alumnae association, Elsie Gruer and Ruth Francis, delegates to the C.N.A. biennial convention in Sackville, gave interesting reports of the activities at this general meeting. The two students who were privileged to attend — Marion Gage and Patricia Denman — participated in the student nurse workshop. An enlightening talk on "Newer Drugs and Therapeutics" was given by Mr. Frank Zahalan, hospital pharmacist.

Bernice Kent, a 1929 graduate, has been appointed director of nursing services, Germantown Dispensary and Hospital, Philadelphia. Miss Kent received her degree of Bachelor of Science in Nursing Education at Villanova College, Pa.

Moira Allen and Mary Harling are with the teaching department. A. R. MacDonald, who recently received the degree of Bachelor of Nursing at McGill University, is in charge of Ward R (male surgical research ward). Edith MacDonald, Norma McKee, Shirley and Ada Hamilton, Winnifred Sproule, Eva Barnhill, Margaret Smyth, and Constance Bebee have resigned from the Central Division staff, the latter three to be married. Elizabeth Chalmers, Pauline Crouse, Isabel MacVicar, and Florence Hewson are recent additions to the staff. Ada Hamilton is now with the Western Division. Elva Honey, who has been with the nursing office, has accepted a position with D.V.A.

Beatrice Adam and Miriam MacLeod are on the staff of the Child Welfare Association of Montreal. Edith MacOuat, Eileen MacCready, and Marie Ford are doing public health at Kirkland Lake, Ont.

Margaret Denniston, director of nursing services, Medical College of Virginia Hospital, Richmond, was a recent visitor to the school.

Letters are being continually received, expressing appreciation to alumnae members

for food parcels which are sent monthly to British nurses.

Royal Victoria Hospital:

Janet MacKay has resigned from the Ross Pavilion staff and is now superintendent of nurses, Lachine General Hospital. Dorothy Dick is assistant director at the University of Manitoba School of Nursing Education. Mary Harling is teaching at the Montreal General Hospital, having completed her degree work at McGill School for Graduate Nurses. Elizabeth Church, who has been doing industrial nursing, is now practising private duty. Elizabeth Gordon has succeeded Miss MacKay as head nurse on 4th floor, Ross Pavilion. Marion Barrett, who since her discharge from active duty has been attending the McGill School for Graduate Nurses, is now medical supervisor, R.V.H. She succeeds Helene Lamont who is now at McGill.

Laura Rasmussen is taking public health nursing at the University of Manitoba. Justine Delmotte, who has been with the International Refugee Organization in Salzburg, Austria, following a term of service on active duty and work with UNRRA, has returned to Canada and is taking public health at McGill. Evelyn Eaton, who is a missionary nurse in India, is spending some time observing in the school here in preparation for opening a school of nursing there.

Mrs. John MacLeod is now living in Lennoxville, Que., where Dr. MacLeod has gone into practice. Mrs. Arthur (Woolner) Bullen has sailed for England where Dr. Bullen will be doing post-graduate work in medicine.

SASKATCHEWAN

QU'APPELLE VALLEY:

A banquet was recently tended by the Fort San staff in honor of Dr. and Mrs. Ferguson. Dr. John Orr, who succeeds Dr. Ferguson as medical superintendent, made the presentation. Tribute was also paid to Dr. Ferguson by the ex-patients of the San. His Honor the Lieutenant-Governor, J. M. Uhrich, and Premier T. C. Douglas both spoke of the great work Dr. Ferguson had done in the treatment and prevention of tuberculosis. A cheque was presented to him on behalf of the ex-patients. Mr. John Fisher, CBC roving reporter, was on hand to report the proceedings.

Mary Montgomery, who was superintendent of nurses at the San from 1919 till 1930, and Agnes Campbell, superintendent of nurses, Prince Albert Sanatorium, were welcome visitors attending the functions for Dr. Ferguson.

REGINA:

At a recent meeting of Regina Chapter, M. Palmer, president, gave a report on the 31st annual provincial convention. A welcome

Good As Gold

What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

BABY'S OWN TABLETS

TO KNOW THAT IN HOSPITAL TESTS

Vapo-Cresolene

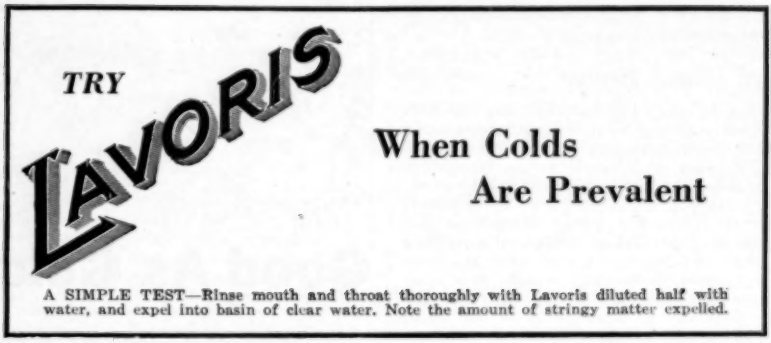
RELIEVED COUGH OF

Whooping Cough in 80% of cases
Bronchial Asthma in 76% of cases
Spasmodic Croup in 100% of cases
Bronchitis in . . . . 83% of cases

Vapo-Cresolene reduces nasal congestion, soothes and relieves the throat irritation that causes coughing.

Send for special brochure
Established 1879

LEEMING MILES CO. LTD.,
504 St.Lawrence Blvd., Montreal 1, Canada


TRY
LAVORIS
When Colds
Are Prevalent
A SIMPLE TEST—Rinse mouth and throat thoroughly with Lavoris diluted half with water, and expel into basin of clear water. Note the amount of stringy matter expelled.

speaker was Ethel James, S.R.N.A. president, who gave the highlights of the C.N.A. biennial convention in Sackville.

General Hospital:

Wilma Peterson has been granted a fellowship by the W. K. Kellogg Foundation and will take a course in clinical teaching at Boston University. She has been instructing at the Saskatoon City Hospital for the past year. D. Ferrier is now assistant nursing arts instructor.

SASKATOON:

The local chapter of the Nursing Sisters' Association recently held a fall tea and fashion show at the Hudson Bay Company, with Mrs. H. Dorrance the general convener. The president, B. Scrinshaw, received the guests.

City Hospital:

Thirty-nine student nurses of the preliminary class recently received their caps at an impressive candle ceremony, the newly-capped nurses contributing to the evening's program.

Recent appointments to the staff include Jorgine Salte, science instructor; Helen Chow, head nurse; Eva Christie, head nurse, maternity department.

Margaret Stephen Newsham has been awarded a scholarship by the Women's Auxiliary of the hospital. She will take post-graduate work at the McGill School for Graduate Nurses. Donalda Munro and Pauline Trasoff are doing post-graduate work at Margaret Hague Maternity Hospital, Jersey City.

St. Paul's Hospital:

Forty new students recently entered the school of nursing. A welcome party was given under the direction of the Student Council in honor of the Freshmen B. The new students underwent psychometric tests, given by an expert from Ohio. The school faculty is very grateful to Sr. Superior for having granted this opportunity of helping to select suitable applicants for the nursing profession. Thanks is extended to Rev. Sr. Ste. Croix by the students for the new electric washing machine and hair drier.

Srs. Quintal, Sauvé, and Ste. Croix have returned after a month and a half leave of absence, during which time they attended the C.N.A. convention in Sackville. Regret is expressed at the departure of Miss O'Callaghan after eight years of service as dietitian. She is replaced by M. Kinnear, B.H.Sc. F. MacDonald, science instructor, has resigned, her position being filled by L. Rechenmacher. The new clinical instructor is M. MacKenzie, replacing M. Robinson.

Rev. Sr. Superior and Sr. Fortier attended a convention in Chicago. Florence (Bateman) Elliott, a 1938 graduate, was a recent visitor.

Saskatoon Sanatorium:

Muriel Jarvis has been appointed superintendent of nurses, succeeding Rhoda Smith who has held this position for many years. Other additions to the staff include: Anna Wolfe, L. Saunders, Edna Messinger, Roghild Dahl, Ivy Powell, Helen Rutherford, Dorothy Lucas. Glycera Zbitnoff has resigned to be married. She nursed in Africa for five years, later joining the San staff. Recently she was acting superintendent of nurses and, prior to her departure, was presented with a chest of silver by the medical and nursing staffs.

SWIFT CURRENT:

Thanks is expressed to Mrs. E. Powley, retiring president. Irene Walner, Daisy Sherwood, and Miss Lusmaster have joined the Union Hospital staff.

YORKTON:

M. Crawford, a former member of Yorkton Chapter, has accepted a position as arts instructor at Regina Grey Nuns' Hospital. Miss Crawford's reports of the C.N.A. convention, which she attended, proved most interesting.

Thirteen preliminary students received their caps at an impressive ceremony held at the General Hospital. D. Hansen, vice-president, Student Council, warmly welcomed the newly-capped students into the student body. A welcome visitor at the hospital was Ethel James, former instructor, and now president of the S.R.N.A.

Positions Vacant

Supt. of Nurses for 188-bed General Hospital in Southern Alberta. Salary: $225 plus full maintenance. Suite in residence. 1 month's vacation with pay after 1 yr.'s service. Equal amount of sick time with pay. Qualification: Experienced administrator. Duties to commence as soon as possible. Apply Acting Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Asst. Matron, Classroom Instructor, Clinical Instructor, Night Supervisor for 130-bed hospital. Apply, stating qualifications, when available, Matron, King Edward VII Memorial Hospital, Bermuda. (Further information on request.)

Registered Nurses (2) for Lamont Public Hospital, Lamont, Alta.—1 for Men's Medical & Men's Surgical Wards; 1 for Evening & Night Supervisor. Alternate wk. shifts. 8-hr. day; 1½ days off each wk. Gross salary: $120 per month. Deduction for board, room, laundry $19.90 per mo. Increase to value of maintenance after 1 yr. continuous service. Apply Supt. of Nurses.

Scrub Nurse for Operating-Room. 8-hr. broken day. Gross salary: $165 monthly. **General Duty Nurses.** 8-hr. broken day. 48-hr. wk. Gross salary: $159 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks.' holiday after 1 yr. service. Write Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Operating-Room Instrument Nurses (2). **General Duty Nurses** for various services. Salary: $150 per month living out. Meals & laundry provided. Apply Supt. of Nurses, General Hospital, Port Arthur, Ont.

Graduate Nurse for General Floor Duty. Salary: $110 monthly. Full maintenance & laundry. Blue Cross hospitalization plan. $60 yearly increase up to 3 yrs. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Public Health Nurse (qualified) for Visiting Nursing in Hamilton, Ont. Salary scale: $2,042-$2,342 yearly. Apply, stating experience, age, religion, Supt., St. Elizabeth Visiting Nurses' Ass'n, 461 Main St. E., Hamilton, Ont.

General Duty Nurses. Salary for Night Duty: $110 per mo.; Day Duty: $100 per mo.—both with room and board. Apply Supt., General Hospital, Kenora, Ont.

Instructor of Nurses, Operating-Room Nurse, General Staff Nurses. Liberal salaries. Excellent living conditions with recreational facilities. 1 month annual vacation. 5-day week. Apply Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, Que.

Obstetrical Supervisor, preferably with a degree, for 250-bed Ohio hospital. 44-hr. wk. Salary: $250 per month plus complete maintenance, including attractive private room, meals, laundry. Apply care of Box 10, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150. and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Staff Nurses, eligible for registration in Mich., U.S.A., needed for all services in modern 200-bed hospital. Salary: $210 per month for 44-hr. wk. 6-month increase. $10 extra for 3-11 & 11-7 duty. 7 legal holidays. 12 vacation & 10 days sick leave per year. Cafeteria meal service. Laundry furnished. Room available at $10 per month. Apply Director of Nurses, General Hospital, Pontiac, Michigan.

District Nurse in Province of Alberta. Rural service. Emergency treatment, preventive and maternity program. Furnished cottage, fuel and water supplied. Salary schedule — $1920 - $2400, plus Cost of Living Bonus. Sick leave, annual vacation, superannuation. Apply to Director, Nursing Division, Department of Public Health, Edmonton, Alta.

Visiting Nurse for Miscou Island wanted immediately. Living quarters, with office, and housekeeper supplied. Also car. Apply to Canadian Red Cross Society, New Brunswick Division, 69 Prince William St., Saint John, N.B.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock, and Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 weeks' vacation, statutory holidays and special holidays with pay. 8-hr. day, 6-day wk. Apply to Supt. of Nurses at above hospitals.

WANTED

SUPERINTENDENT OF NURSES

by

THE GALT HOSPITAL, LETHBRIDGE, ALBERTA

120-beds—Training School

New 150-bed hospital under design

Apply to:

Secretary-Treasurer, Galt Hospital, Lethbridge, Alberta

Vancouver General Hospital has positions vacant for **General Staff Nurses.** Salary: $155 (plus laundry) increasing to maximum, $185. Extra $5.00 all-night rotation shifts. 4 wks' vacation & 11 statutory holidays with salary. Superannuation. Sick leave allowances. Registration in British Columbia essential. Apply Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Registered Nurses for General Staff at Tranquille Sanatorium, situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hr. day, 5½-day wk.: $174 per month during 1st yr., $186 per month for 2nd yr. & $5.00 raise per month in 3rd, 4th, and 5th yrs. of service, minus $27.50 for board, room, laundry. 31 days' vacation per annum with pay plus 11 days statutory holidays. 14 days sick leave each yr. accumulative with pay plus 6 days incidental illness. Superannuation Plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Registered Nurses for staff positions. Initial salary: $131:50 per month with full maintenance. Good living & working conditions. Apply Supt. of Nurses, Central Alberta Sanatorium, Calgary, Alta.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospital for Crippled Children, Montreal Unit, Que.

Registered Nurses for General Duty (3). Salary: $140 per month with full maintenance. New hospital with fully modern nurses' home in process of building. At present hospital of 30 beds on main line between Saskatoon & Calgary. Town of 1,500. Apply Miss E. Nixon, Matron, Union Hospital, Kindersley, Sask.

Registered Nurses for General Duty. 60-bed hospital. Salary: $140 per month plus full maintenance. Well-equipped nurses' residence in town of 4,000. Also **Night Supervisor.** Apply Supt., Lady Minto Hospital, Cochrane, Ont.

Graduate Nurses (2) for General Duty for the R. W. Large Memorial Hospital of the United Church of Canada, located at Bella Bella on the B.C. coast, 300 miles north of Vancouver. Position open Nov. 1 & Dec. 1. Salary: $150 gross, less $25 per month for maintenance. Fare to hospital refunded after 1 yr. of service. Apply to Matron.

Graduate, Registered Nurses for 250-bed hospital in northeastern Ohio. 44-hr. wk. Gross salary: $190 day duty; $200 night duty; $210 evening duty. Attractive living quarters available at nominal rates. Apply care of Box 11, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

General Duty Nurses (2) for small hospital in Peace River Country. Salary: $130 per month with full maintenance. 8-hr. day, 6-day week. Holidays and sick leave with pay. Cosy separate nurses' residence. Transportation costs from Edmonton refunded after six months' employment. Write or wire collect to Secretary-treasurer, Berwyn Municipal Hospital, Berwyn, Alta.

Graduate Nurses for Red Cross Outpost Hospitals in Saskatchewan. Salary: $160 per month less $25 maintenance. Added increment of $5.00 per month given on completion of each yr's service. 8-hr. day, 6-day wk. 1 month's holiday with pay annually. Apply Commissioner, Canadian Red Cross, Saskatchewan Division, Regina, Sask.

Supt. (Registered Nurse) for 56-bed hospital. Apply, stating salary expected, date available, age, experience & full particulars, to E. H. Rath, Sec.-Treas., Municipal Hospital, Stettler, Alta.

Matron immediately for 30-bed hospital situated in Southern Interior of B.C. Gross salary: $160 less $20 maintenance. 8-hr. duty. 4 wks. vacation with pay after 1 yr. Also 9 statutory holidays. Apply Mr. A. Rutherford. Sec.-Mgr., Community Hospital, Grand Forks, B.C.

General Duty Nurses immediately for 30-bed hospital situated in Southern Interior of B.C. Gross salary: $140 less maintenance of $20 per month. 8-hr. duty. 4 wks. vacation with pay after 1 year. Also 9 statutory holidays. Generous recreational facilities. Close to U.S. border. Apply Mr. A. Rutherford. Sec.-Mgr., Community Hospital, Grand Forks, B.C.

Operating-Room Nurse. Experience not essential. Apply Director of Nursing, County General Hospital, Welland, Ont.

Graduate Nurses for 22-bed hospital, situated in excellent Western town in Foothills of Rockies (3-hr. drive to Calgary or Edmonton). Salary: $125 per mo., plus $50 bonus at end of every 6 mos. Transportation paid after 6 mos. service. Full maintenance with laundry. 1 mo. holiday & 12 days sick time with pay after 1 yr. service. Write or wire Matron, Rocky Mt. House Hospital, Rocky Mt. House, Alta.

Graduate Nurse for General Duty. 33-bed hospital on sea-front. Salary: $155 gross. Board, lodging, laundry: $35. Vacation: 28 days after 1 yr. Statutory holidays & usual sick leave: Apply Matron, General Hospital, Chemainus, Vancouver Is., B.C.

Registered Nurses for General Duty. 60-bed hospital. 8-hr. duty. 6-day wk. Salary: $120 plus maintenance. Apply Sister Superior, St. Joseph's Hospital, Kenora, Ont.

Asst. Night Supervisor for General Hospital with School for Nurses. 8-hr. day; 44-hr. wk. Alternating 4 wks. 3:30-12 & 4 wks. 11:30 p.m.-7:30 a.m. Salary living out: $160 plus 1 meal. Apply, stating qualifications, experience, references, when services available, in c/o Box 12, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

General Duty Nurses for modern 20-bed hospital. Salary: $135 per month with maintenance. 8-hr. day; 6-day wk. Usual holidays. Apply Miss A. Scott, Mayerthorpe Hospital, Alta.

Operating-Room Supervisor for 165-bed hospital, connected with large clinic. Capitol City with many interests. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Keep it Simple

I have a few words for those who favor a basic simplicity of speech. To those who insist on the circumlocutive concatenations and the dialectic ambiguities of a professional jargon what I am about to say will make no appeal. Nor are these remarks intended for the timid souls, many of whom nurture their wisdom in guilty secret, lest their utterances prove them brash.

There remains quite a large class of nurses who may be described as likely, if all goes well, to become speakers of good uncluttered English. This is a most interesting condition to be in. The mind is alert, not littered with prejudices and fixations, receptive to every precept delivered with authority. Therein lies our responsibility. The brain is firm and pliant. The tongue is unaffected, free from the "ahs" and "isms" of the longwordians. Pen and paper tell a simple story in bright shiny words that appeal to the layman as well as to the profession itself.

Words themselves are wonderful when well understood and resourcefully used, but we must never lower their dignity and ours by using them to impress the inexperienced.

Into our daily speech has crept a wealth of: integrations, implementations, interpretations, orientations, challenges, evaluations, concepts, criterions, and cognizances. All honorable words, but in danger of becoming clichés and too often displacing the humbler, the more common, and better understood word from which they sprang. Of these are: sum, mass, total, lead, admit, introduce, trial, doubt, explain, teach, define, answer, appraise, sort, and test. These also serve as well as their more haughty pre- and suf-fixes, and the happy "ism" so dear to the philologists.

I value and I treasure the beauty of words, and I would be the first to deplore the use of mere journalese by our profession.

We don't begrudge the musician his arpeggios and scales as the exercises which ensure the perfection of his artistry, but we don't go to the concert hall to hear these. There we expect the full-bodied rhythm and harmony of the composer's music.

We likewise must ensure that our public utterances are uncluttered with exercises and stylized jargon. — D.R.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, Que.

President..... Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont.

Past President..... Miss Rae Chittick, 815-18th Ave. W., Calgary, Alta.

First Vice-President..... Miss Evelyn Mallory, 1086 West 10th Ave., Vancouver, B.C.

Second Vice-President.... Miss Marion Myers, Tuberculosis Hospital, East Saint John, N.B.

Third Vice-President..... Miss Lyle Creelman, c/o Canadian Public Health Ass'n, 150 College St., Toronto 2B, Ont.

General Secretary-Treasurer... Miss Gertrude M. Hall, Suite 401, 1411 Crescent St., Montreal 25, Que.

OTHER MEMBERS OF EXECUTIVE COMMITTEE

Presidents of Provincial Associations—

Alberta..... Miss Blanche Emerson, 23 Rene LeMarchand Mns., Edmonton.

British Columbia..... Miss Evelyn Mallory, 1086 West 10th Ave., Vancouver.

Manitoba..... Miss Irene M. Barton, Veterans' Home, Winnipeg.

New Brunswick..... Miss Marion Myers, Tuberculosis Hospital, East Saint John.

Nova Scotia..... Miss Maisie Miller, Victoria General Hospital, Halifax.

Ontario..... Miss Nettie D. Fidler, 849 Kildare Rd., Windsor.

Prince Edward Island..... Mrs. Lois MacDonald, P.E.I. Hospital, Charlottetown.

Quebec..... Rév. Soeur Valérie de la Sagesse, Hôpital Ste-Justine, Montréal 10.

Saskatchewan..... Miss Ethel James, General Hospital, Regina.

(In addition to the presidents, one other member of the administrative body of each provincial association or its executive secretary is a member of the Executive Committee.)

Religious Sisters (Regional Representation)—

Maritimes..... Rev. Sister Mary Beatrice, St. Joseph's Hospital, Glace Bay, N.S.

Quebec..... Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25.

Ontario..... Rev. Sister St. Albert, St. Michael's Hospital, Toronto 2.

Prairies..... Rev. Sister Mary Irene, Holy Family Hospital, 15th St. W., Prince Albert, Sask.

British Columbia..... Rev. Sister Mary Claire, St. Joseph's Hospital, Victoria.

Chairmen of National Committees—

Constitution, By-laws and Legislation..... Miss Nettie D. Fidler, 849 Kildare Rd., Windsor, Ont.

Educational Policy..... Miss Agnes Macleod, Treatment Branch, Dept. of Veterans Affairs, Ottawa, Ont.

Institutional Nursing..... Miss Elinor Palliser, General Hospital, Vancouver, B.C.

Labor Relations..... Miss Ina Broadfoot, Canadian Red Cross, 31 Kennedy St., Winnipeg, Man.

Private Duty Nursing..... Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont.

Public Health Nursing.... Miss Trenna Hunter, Metropolitan Health Committee, City Hall, Vancouver, B.C.

EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses, Miss E. Bell Rogers, Reynolds Bldg., 10028-102nd St., Edmonton.

Registered Nurses' Ass'n of British Columbia, Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.

Manitoba Ass'n of Registered Nurses, Miss Lillian Pettigrew, 214 Balmoral St., Winnipeg.

New Brunswick Ass'n of Registered Nurses, Miss Alma F. Law, 29 Wellington Row, Saint John.

Registered Nurses' Ass'n of Nova Scotia, Miss Nancy Watson, 301 Barrington St., Halifax.

Registered Nurses Ass'n of Ontario, Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

Prince Edward Island Registered Nurses' Ass'n, Miss Verna Darrach, 62 Prince St., Charlottetown.

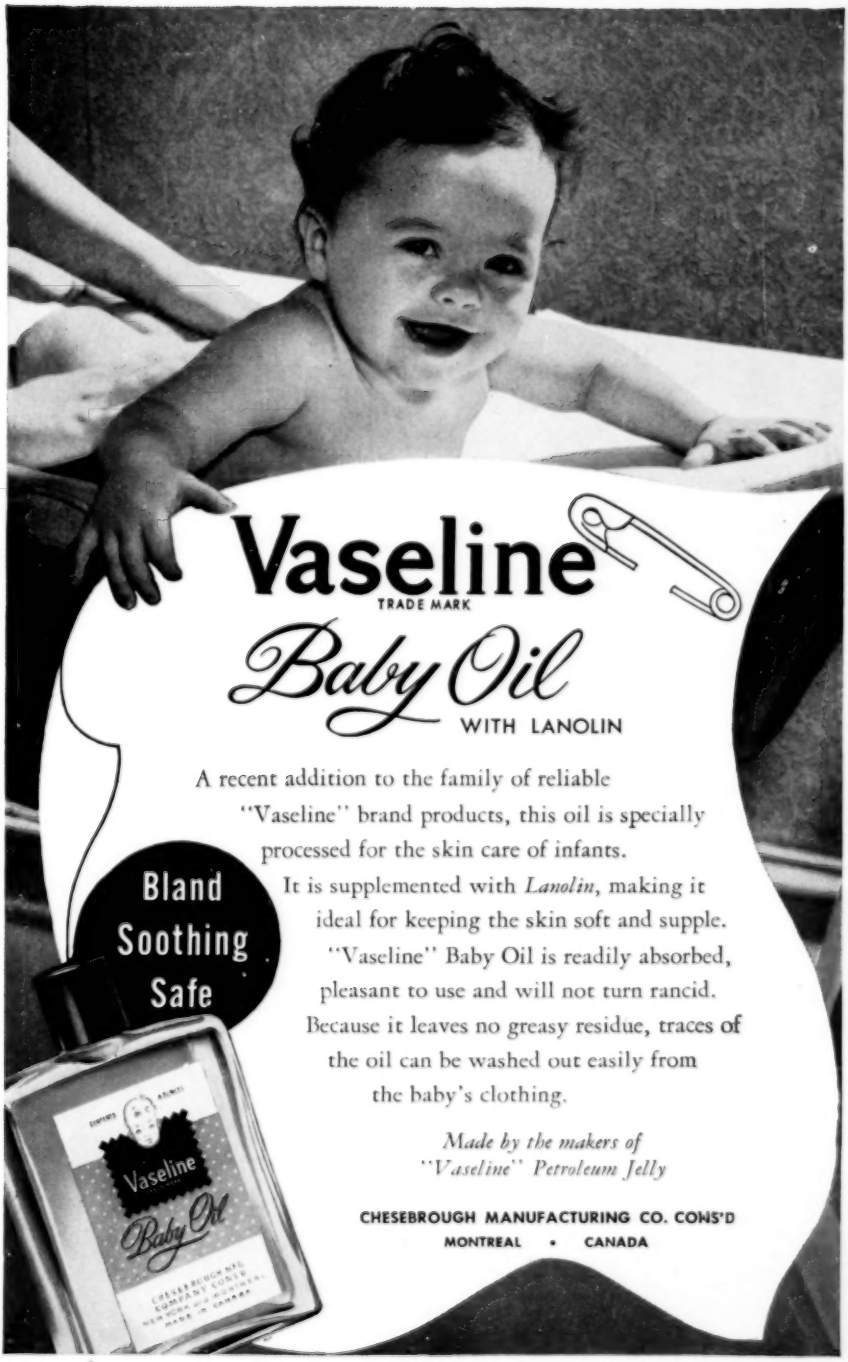
Association of Nurses of the Province of Quebec, Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25.

Saskatchewan Registered Nurses' Ass'n, Miss K. W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

ASSOCIATION OFFICERS

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, Que. *General Secretary-Treasurer*, Miss Gertrude M. Hall.

International Council of Nurses: 19 Queen's Gate, London S.W. 7, England. *Executive Secretary*, Miss Daisy C. Bridges.


Vaseline
TRADE MARK
Baby Oil
WITH LANOLIN
A recent addition to the family of reliable "Vaseline" brand products, this oil is specially processed for the skin care of infants.
It is supplemented with *Lanolin*, making it ideal for keeping the skin soft and supple.
"Vaseline" Baby Oil is readily absorbed, pleasant to use and will not turn rancid.
Because it leaves no greasy residue, traces of the oil can be washed out easily from the baby's clothing.
Bland
Soothing
Safe
Vaseline
Baby Oil
Made by the makers of "Vaseline" Petroleum Jelly
CHESEBROUGH MANUFACTURING CO. CONS'D
MONTREAL • CANADA